Towards resident-oriented environments within elderly persons' homes

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TOWARDS RESIDENT-ORIENTED ENVIRONMENTS WITHIN ELDERLY PERSONS' HOMES

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In relation to the research process itself my thanks are due to the residents and staff of all the establishments I visited for the generous ways in which they gave me access to their homes; without their help this research would not have been possible. I am particularly grateful to Barbara Newman, the then officer in charge of the home in which the action research was undertaken, and Erica Jones, Social Services Officer, who gave both official and personal encouragement and helped administer the schedules.

Linda Challis provided supportive supervision throughout, Andrew Kerslake acted as group work consultant on a much-appreciated occasion and Judy Harbutt typed the final copy with speed and efficiency.

I would also like to thank Howard Burton for his generous personal support and encouragement; and David and Matthew Burton who have lived with this research, with considerable tolerance, for much of their lives.

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ABSTRACT

This research constitutes an investigation into the difficulties encountered over the years in moving away from institutional practices towards more resident-oriented environments within elderly persons' homes.

A brief historical analysis of residential provision for elderly people forms the basis of Chapter 1. Chapter 2 is a resume of the literature relating to what is currently thought to be wrong with residential care and suggestions about how to improve matters. Chapter 3 is a description and analysis of a piece of action research undertaken with the staff of one local authority elderly persons' home, with the explicit aim of trying to enable them to move towards more resident-oriented practices. This endeavour was successful insofar as some changes were introduced which were sustained over time, but barriers to change were also encountered in the guise of prevailing staff attitudes of 'we know best.' Chapter 4 outlines the problems experienced, concluding with two hypotheses regarding optimum factors for the achievement of improved residential environments.

These hypotheses were explored and tested further in a survey of all the homes in one local authority where the officer in charge had been in post for at least two years. The survey confirmed the importance of attitude and other factors as predictors of regime. The survey and its findings are

outlined in Chapters 5 and 6, whilst Chapter 7 summarises the overall conclusions of the research.

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INTRODUCTION

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Like any endeavour this piece of research has a history. It began with a concern about institutional dependence and an idea of working with the staff team of one elderly persons' home in order to help bring about changes in practice which would result in a residential environment better able to meet the individual needs of residents. The intervention was partially successful insofar as some significant changes were introduced into the home, but it also highlighted the inherent difficulties of achieving change, which seemed to centre around staff attitudes towards residents. This led to the second part of the research which may be seen as a theoretical and empirical exploration of the difficulties encountered in attempting to achieve resident oriented environments and an attempt to identify the optimum factors for the achievement of such environments.

Successive studies relating to the life of elderly people in residential establishments have documented the deleterious effects of admission on the autonomy of the individual (Robb 1967, Townsend 1962 and Meacher 1972) and the widespread incidence of the resultant institutional dependence (Goffman 1961, Barton 1959, 1976). Others have suggested ways of moving towards more resident oriented institutional environments, for example Brearley (1977), Clough (1981), Goldberg and Connelly (1982), Willcocks et al. (1982) and Greenwell (1985). However,

there are few systematically recorded empirical studies testing these ideas in practice. In addition a recent and extensive study of actual practice in elderly people's homes (Godlove et al. 1982) led Booth (1982) to conclude, "Over 20 years of research-based criticism has done little to change important aspects of institutions."

This research is an attempt to further understanding of the reasons why resident oriented environments have proven so difficult to achieve over the years, and to explore some ways in which such difficulties may be overcome.

Chapter 1 provides an historical overview and analysis of residential provision for elderly people. Chapter 2 is the result of an extensive literature search designed to ascertain what is currently thought to be wrong with institutional environments and what might be done to improve them. Chapter 3 details the results of a case study in which the researcher undertook a piece of action research in one local authority elderly persons' home, which was explicitly designed to use current knowledge and understanding in an attempt to help the staff to move towards a more resident oriented institutional environment.

As a result of this work, certain hypotheses were formulated regarding the difficulty in achieving resident oriented environments and how to overcome it. These interim conclusions

form the basis of Chapter 4. Chapters 5 and 6 outline the ways in which the hypotheses were tested via a survey of all the elderly persons' homes in one local authority, whose officers in charge had been in post for at least two years. The conclusions are written up in Chapter 7.

The research undertaken was of necessity interdisciplinary in nature, drawing upon sociology and psychology as well as upon more technical areas of knowledge such as group work, action research and adult learning. In the field of intervention in particular there is a paucity of systematic theory and thus it was necessary to adopt an eclectic approach, borrowing ideas from a variety of sources.

Jones and Fowles (1984) write, in relation to the need for future work on institutions, that what is required is, "Middle range idea-and-reality theory which can be operationalised into a theory of practice." It is hoped that this study will constitute a small contribution towards such enterprise.

Finally the following quotation serves as an eloquent raison d'etre for undertaking this research:-

> The aged are as sensitive, if not more sensitive to their environment than other adults. Rendered vulnerable by poor physical condition, continual crisis, prejudice and isolation, the aged are easily victimised by uncongenial environments. Therefore a major task for researchers is to carefully evaluate environments in order to determine how they best can be used to support the aged. And a major task

for practitioners is to provide the environmental supports needed by the elderly to replace those which have fallen away from them. There is reason to believe that the aged, at any level of competence, will respond particularly if helped to play an active participating role in their own care. (Bennett and Eisedorfer 1977).

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CHAPTER 1

FROM FEUDAL PATERNALISM TO THE SECOND 'NEW INDIVIDUALISM': AN HISTORICAL OVERVIEW

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The history of residential care for elderly people begins with the voluntary organisations; develops with the increasing involvement of the state in providing accommodation; and is brought up to date by an unprecedented growth in provision by the private sector. Accompanying these fluctuations in the source of provision have been varying attitudes towards old age, particularly in relation to whose is the responsibility for those elderly persons unable, by virtue of impairment or poverty, to maintain themselves in their own homes.

Before the 1601 Poor Law Act was passed, the care of elderly people was not seen to be the responsibility of the state at all. The only residential accommodation was provided voluntarily, primarily by the church, for example in monastic almshouses until the reformation (Brearley 1977). The Checklands (1974) see the Elizabethan Poor Law Act of 1601 arising as a consequence of the prevailing feudal Christian view of society, which placed upon the landowners a moral duty to give to the poor and destitute. Thus, whilst society was seen in hierarchical terms, it was also characterised by a paternalistic concern for those in need, and a feeling of moral responsibility to intervene. At this time then came the recognition that 'the state did, after all, have a duty

towards those in need' (Hurley 1974). Thus the 1601 Poor Law Act put the responsibility for the needy on the parish and for the next several hunded years residential provision for elderly people was in workhouse environments in which old and young, blind, sick and disabled people lived together. In addition to indoor relief in the workhouse a system of outdoor relief enabled some able-bodied needy people to continue to live outside the workhouse. These were the state's first tentative steps towards involving itself in the welfare of its citizens. It is interesting to note that at this time, and indeed until the latter part of the nineteenth century, elderly people were not seen as a discrete group for whom special provision was required, but as part of a larger group of people whose problem was that they were poor and unable to maintain themselves.

With the growth of the new middle classes, which emerged with industrialisation, the older paternalistic views of society were challenged by a 'new individualism' (Checkland and Checkland 1974) which 'asserted the autonomy of the individual, his responsibility for his actions and his honourable title to his economic gains... This justification had its reciprocal, ... those who did not make economic gains, or who were unable to maintain themselves ... had failed in their responses ... (There was) a general air of moral approval over economic success.' (page 20). This changing view of society, together with a fear that outdoor relief would lead to a widespread deterioration into

idleness on behalf of the working class, provided the rationale for much of the 1834 Poor Law Amendment Act which grouped parishes into larger Unions supervised by Boards of Guardians. However, as suggested above, this administrative reorganisation was accompanied by a hardening of attitudes towards people who found themselves reliant 'on the parish.' This harsher attitude was expressed in the reduction of outdoor relief and the emphasis, within the workhouse, on conditions worse than those outside, in an attempt to discourage people from abdicating from their responsibility to care for themselves and their families. Mishra (1977, 1981) views the attitudes underlying the 1834 Poor Law Amendment Act and the provision arising from it as a residual model of welfare ideology: that is one which sees the state responsibility for meeting need as minimal.

Despite the legislators' concern to reduce to a minimum the population within workhouses, and the dread with which such a move would be perceived by the populace, generally low wages, the increasing paucity of outdoor relief and high unemployment meant that between 1850 and 1900 up to thirty three percent of the population had to resort to poor relief at some point in their lives (Brearley 1977). The outdoor relief pensions during this period were reduced both in number and in value, being in 1900 only one third to one half of their value in 1850 (Thomson 1983).

Attitudes towards elderly people in need of help were perhaps at their harshest at the time of the 1834 Poor Law Amendment Act and in the decades that followed. Townsend (1962) described conditions in the workhouse after 1834 as being 'harsh and spartan' and equated the care people received in them with containment. He, and many others, believe that attitudes towards residential care today are coloured by the 'fear and dread' of the workhouse and the sense of personal failure attributed to the people who lived there. Old age alone was not seen at this time to be a criterion for state aid. Increasingly those elderly people seen as in need of outdoor relief, by virtue of their poverty, were given insufficient money with which to maintain their economic independence and at the same time conditions within the workhouse, the only alternative open to them, became more punitive. At a time when the value of self reliance was being strongly asserted, structural aspects of society, such as low wages, unemployment and fewer and lower pensions, were forcing increasing numbers of people into the workhouse with its accompanying shame and stigma. Thus, at a time when many individuals were suffering increasing economic hardship, any notions of collective responsibility for the meeting of human need were lost or severely weakened in the ethos of the 'new individualism.'

Thomson (1983) notes that in the 1850's there were 40 workhouses having an average of 300 bed spaces in each. Elderly people though constituted a minority of the workhouse population,

comprising less than twenty percent of the total in 1851. Interestingly at this time there were more elderly men in many workhouses than women. However, during the latter part of the nineteenth century many, including children and sick people,were excluded, leaving elderly people and those with chronic conditions as an increasing proportion of the workhouse population.

Gradually attitudes towards poverty began to change, as did governments' views about their role in ameliorating it. At the same time there was an increasing recognition that old age in itself was something about which the state should concern itself. This concern and softening of the attitudes found expression in many of the liberal reforms around the turn of the century and in the growth of the new Labour Party. Thus, for example, in 1908 the first pension specifically for old age was introduced. Later, in 1925, this was extended via the principle of social insurance, which introduced the idea of people receiving benefits as of right because of their past contributions rather than as a charity (Brearley 1977). Nevertheless, in 1930 the Poor Law Act reconfirmed its commitment to family responsibility for elderly people (Means and Smith 1983). The workhouses, despite being renamed Public Assistance Institutions (Peace et al. 1982), remained also, although the Local Government Act of 1929 transferred the powers of the Boards of Guardians to county councils who were empowered to reclassify some as hospitals.

Overall reform was slow to come and it took the second world war (1939-1945) to provide the catalyst for many of the social reforms which were to herald the beginning of the end of the Poor Law and the workhouse and the introduction of what is generally known as the Welfare State. Henriques (1979, page 268) views the Welfare State as representing 'at least in theory the total reversal of nineteenth century attitudes.' Instead of seeing poverty as the fault of the poor and therefore any provision needing to be punitive and minimal, poverty was seen as the responsibility of the state to ameliorate, and there was some notion of optimum standards to which the whole population was entitled. Mishra (1977, 1981) echoes this view of a radical difference in his distinction between the residual model of welfare exemplified in the 1834 Act and the institutional model, of which the Welfare State is an illustration.

After 1945 workhouse buildings tended to be used largely for elderly people and at that time there was concern expressed about conditions within them. As a result The Nuffield Survey Committee was set up in 1944 to investigate. Its findings were published (Nuffield Foundation 1947) and it recommended much smaller homes for 30 to 35 people. The report influenced the post war Labour government and in part was responsible for the 1948 National Assistance Act, Part Three of which placed upon local authorities a duty to provide 'residential accommodation for persons who by reasons of age, infirmity or any other circumstances are in need

of care and attention which is not otherwise available to them.' It is this legislation which still today provides the legislative context for residential accommodation for elderly people.

This piece of legislation marked a major shift in attitude on several counts. Firstly it asserted that places in these special homes should be available as of right and on demand, which meant that, apart from spouses, the state was taking responsibility for provision, rather than seeing it as the province of the family. Secondly it suggested that people would pay for their accommodation with their pensions, retaining the residue for personal expenses. This arrangement, somewhat akin to going to an hotel, represented a radical shift from the punitive attitude towards the inmates of the workhouse.

Means and Smith (1983) note that these attitudinal changes occurred during the war time years when elderly people were still seen as having a lower priority than children. They suggest that possible reasons might have been the increasing numbers of middle class people who required services during this time and the concern for civilian morale. They also suggest that a more positive image of residential care may have emerged from the experience of the evacuation hostels set up during the war. These were interesting because clearly residence in them, unlike the workhouse, could not be seen as the fault of the inmates and

therefore the regime no longer needed to be punitive to discourage over-use. They also, like many other war-time experiences, made more affluent people aware, perhaps for the first time, of the conditions under which many others had to live. Whatever the reasons, however, attitudes did change and residential care was seen, at least potentially, to represent a 'positive choice' for people nearing the end of their lives (Means and Smith 1983).

The liberalising attitudes referred to above did not however result in the 1948 National Assistance Act alone. There was at this time a great force for change in the country towards a more egalitarian and caring society. Walker (1984) argues that this, together with other earlier and subsequent changes in the emphasis given to collectivist or individualistic approaches to welfare, was due to the dynamic 'balance of the conflict between the dominant and subordinate classes in society.' Thus the development of the welfare state was based upon 'the ascendancy of a particular set of values and beliefs in the long term structural conflict between social classes in Britain.' (Walker 1984, page 27).

In this more collectivist climate social welfare was not the only subject for progressive legislation. A whole series of Acts of Parliament were passed in the 1940's which formed a package which was said to constitute the Welfare State. For example the 1944

Education Act introduced free compulsory secondary education for all children and the National Health Service was also founded around this time. This latter piece of legislation established the origin of the distinction between residential and hospital provision for elderly people; the source of many present day tensions, not least different funding arrangements. David Wilkin (1984) for example, maintains that, "The architects of the Welfare State unwittingly created an artificial divide between the healthy and the sick, reinforced by the organisational divide between local authorities and the National Health Service and the professional divide between nurses and social workers." This, he argues, militates against the needs of elderly people which may change over time, requiring their use of both services.

Nevertheless that analysis was made with the benefit of hindsight and at the time no such problems were foreseen. Indeed, great pride was taken at the prospect of the demise of the workhouse, and the introduction instead of 'special homes' for which elderly people would pay twenty one shillings a week for rent, leaving five shillings for personal expenditure (Means and Smith 1983).

Sadly, however, insufficient funding resulted in too few homes being built and far too many old Public Assistance Institutions, admittedly up-graded physically, being retained. In addition many establishments continued to be staffed by people who had spent their working lives in the poor law tradition and were unable

easily to change their attitudes or approach. Even as late as 1960 old P.A.I. buildings made up fifty percent of Part Three accommodation.

In the early 1950's the emphasis was still upon small thirty to thirty-five bed homes and many local authorities converted old country houses, although some new homes were built also. By 1955, however, the then Ministry of Health suggested that new homes of up to sixty beds be built to cater for 'the increasing proportion of very old and infirm residents' (Peace et al. 1982). Thus only seven years after the 1948 National Assistance Act was passed, it was recognised, at least by implication, that residential care was not available as of right, as had been envisaged, and neither had the homes succeeded in becoming financially self-sufficient. As a result the rationing of places was introduced in the form of assessment and the consequence was a higher proportion of frailer people in the residential population. This trend towards frailer residents also resulted in a debate about the distinctions between hospital care and residential care which culminated in 1965 (Ministry of Health circular 18/65, HMSO) in broad categories being devised of people for whom residential care was seen as appropriate.

The larger sixty bedded homes, however, were also a disappointment, becoming more institutional and being characterised by lowering staff morale. At the same time came Townsend's swingeing

critique of residential care (1962) which crystallised the dissatisfactions with the post-war developments and led to further serious research and re-analysis of regimes and policies. Peace et al. (1982) maintain that it was the continuing workhouse tradition and the often unquestioning reliance on a medical model of care which resulted in the rigid regimes Townsend exposed in The Last Refuge. Such regimes were characterised by a denial of 'privacy, choice and capacity for self care and self determination,' (Peace et al., op cit).

Evidence of a prevailing medical model of care in elderly persons' homes can still be seen today in some authorities where a nursing qualification is seen as appropriate for senior staff and where terms such as 'matron' persist. In many ways the medical model is institutionalised in the hierarchical staffing structure and is reinforced by the attitudes of some visiting GP's whose expectations are that staff will operate as 'their' nurses. This predominance of the medical model, particularly in the past, reflected perhaps the relative newness of a social work approach and its more dubious claims, in the public view, to profesional status compared with the old-established medical profession.

Townsend's work, however, exposed to public scrutiny the worst excesses of these institutions and the extent of the gap between the intentions of the authors of the 1948 National Assistance Act

and the actual practices within the homes set up under its auspices.

Increasingly people began to emphasise alternatives to residential care such as housing schemes and community care as well as more careful selection to homes, thereby moving further away from the intention that places should be available as of right and on demand. At the same time concern was increasingly expressed about the need for the residential home itself to make links with the community it served. Brearley (1977) for example maintains that, "Residential care was increasingly seen as a community resource to be used as part of a treatment approach to elderly people in care." Regimes, too, within homes were also under scrutiny and two documents published by the Personal Social Services Council (PSSC 1975 and 1977) showed a commitment to a new philosophy of care, which represented a conscious move away from a medical model towards a more social model of care, characterised by minimal routines; an emphasis on domestic or homely atmosphere; and the recognition of the importance of social and emotional needs as well as the physical needs of residents. This approach was also reflected in Building note number 2 (DHSS 1973) which recommended a 'domestic as befits function' style of building and the introduction of group living to begin to break down the large group size.

There is abundant evidence, however, (see for example Willcocks et al. 1982 and Booth 1985) that this new philosophy never became common practice despite laudable intentions. Since the 1970's, demographic changes and significant shifts in government ideology in relation to welfare have taken place. Mishra (1984) for example maintains that the period from 1945 to the 1970's was characterised by a political consensus which accorded the welfare state considerable legitimacy, but that that legitimacy is now lost or at least severely weakened."As far as social policy is concerned the years between 1945 and 1979 will be remembered as a period of broad consensus about welfare objectives," (Bean, Ferris and Whynes 1985, page 196). At the same time the Checklands were writing, "Political belief in the efficacy of individualism is far from dead. In Britain in the 1970's under its Conservative government, there is a revival of concepts embodied in a range of policy measures, that stress individual responsibility." Thus in Mishra's terms (1977, 1981) there was a movement away from an institutional model of welfare ideology back towards a more residual model, with accompanying changes in attitude.

In particular these changes in attitude have found expression in terms of greater commitment to care in the community, which can be seen as a return to ideas of individual and family rather than state responsibility for elderly people in need of care. It also means that a higher proportion of the cost of care is borne

privately (see Walker 1982) rather than publicly. In practice that care is invariably provided by women, who frequently lose their financial independence as a result, until very recently being unable even to claim certain benefits if they were married.

It has been suggested that the economic slump, and particularly large scale unemployment, has reduced national income at the same time as increasing the demand for public expenditure on, for example, DHSS benefits (see for example Mishra 1984) and that this lies at the root of the move away from the general acceptance of the tenets of the Welfare State. However in relation to elderly people in particular, another factor appears to have been significant demographic changes in the age structure in recent years. The most dramatic change is in the number of people who live to very old age. Since 1951 the number of people over retirement age increased by forty percent from 6.9 million to almost 10 million in 1981. However the increase in the number of very old people over the same period of time was even more marked: an increase of sixty percent for the 75 to 84 year olds and one hundred and fifty percent for the over 85's. Projections to the turn of the century suggest that the overall number of people over retirement age will remain fairly constant but that the number of over 75's will increase by about thirteen percent (HMSO 1983).

These changes have significant implications for residential provision since it is very old poeople who are more likely to require residential accommodation. Six percent of all over 60/65's are in hospital or residential care, but that overall figure masks a great age differential in that only three percent of under 75's are in residential accommodation (of both types) compared with twenty one percent of over 75's (Marshall 1983). In addition Wilkin (1981) maintains that, "Since the setting up of the welfare state the number of elderly people has increased more rapidly than the stock of accommodation." The consequence, of the increase in the number of very old people and the failure to provide residential accommodation on the same scale for them, is an older residential population which is characterised by higher levels of physical dependency. The average age for admission is now over 80 and the percentage described as 'substantially dependent' has increased from seventeen to twenty four percent between 1970 and 1981 (Allen 1984). Of these elderly residents, the majority, seventy five percent, are women and this percentage increases with age since the expectation of life for men is considerably lower than for women (Peace et al. 1982).

Wilkin (1984) argues that the increase in the numbers of the very old; the fact that local authority residential provision, in a period of cuts in public expenditure, has not kept up with the demand for it; the current emphasis on care in the community; political encouragement; and social security top-up funding

becoming available have all combined to result in the 1980's in an unprecedented growth in private provision. Thus for example DHSS statistics (1982) show that between 1976 and 1981 the number of people in local authority residential accommodation increased by 5.7% to 103,295, whereas the number in the private sector had increased over the same period of time by 49.3% to 31,838.

Nevertheless, despite public expenditure cuts, care in the community initiatives and the expansion of the private sector, "There are few now who would argue that it (local authority residential provision) is no longer necessary." (Allen 1984, page 65). Indeed Parker (1984, page 73) suggests that 'there is an irreducible minimum demand for residential care,' whilst Hatch (1984, page 86) maintains, "Current trends are for social services departments to be the providers of a declining proportion of a growing volume of residential care, and for the people they care for to be increasingly dependent." This view is echoed by Allen (1984) who sees the main changes in people at admission being their increased levels of incontinence and confusion. She describes the projected increase of half a million over 85's as of 'enormous importance' since senile dementia increases rapidly with old age. For example six percent of over 65's suffer from it, but the percentage rises to twenty two percent for the over 80's.

Several writers, for example Walker (1982) and Means and Smith (1985), maintain that the increase in the numbers of the very old has resulted in greater political and professional concern about elderly people which is frequently expressed in 'burden of dependency' terms (Means and Smith 1985, page 358). Thus the very old are presented as demographically abnormal people, kept alive artificially despite their senility, who are somehow seen as 'less than full human beings.' This negative imagery they suggest lends credence to current pleas for 'more modest pension expectations.' Walker (1982, page 122), however, argues that at least some of the dependency is socially constructed by, for example, 'the equation of dependency with certain natural stages of the life cycle' such as old age. His view is that there is an essential contradiction between on the one hand 'dependency creating policies of the state' and on the other a reluctance under 'the new individualism' to provide adequate care for elderly people. At present the social costs of this contradiction are borne privately, largely by women. Phillipson (1982) argues that ideas of dependency in old age are socially constructed to meet the needs of a capitalist economy; for example in relation to lowering the age of retirement in a time of high unemployment. This analysis is supported by evidence quoted by Thomson (1983) which shows, for example, that since 1945, whilst the old age pension has remained at forty percent of average wages, the total resources available to elderly people as measured by the Family Expenditure Survey, have declined from eighty three percent to

sixty eight percent in the 1970's of those available to non-aged people. Thus once again in real terms there is dwindling residential provision at the same time as independent living in the community is becoming financially more difficult.

Both Walker and Means and Smith argue for a different more collectivist approach to welfare, in which people are seen to have the right to 'financial support, health facilities and social care in old age' according to need, and where a more positive image of old age is fostered.

In the latter half of the 1980's then, social welfare is characterised by two conflicting ideologies: the second 'new individualism' expressed by the present Conservative government on the one hand and on the other the demand for rights and the assertion that economic gain should not take precedence over social need.

These two conflicting ideologies have also affected in different ways local authority residential homes for elderly people. The first has resulted in an older and frailer resident population with no increase in staffing levels, but the second is also apparent in current social work values which assert people's right to self determination and which found expression in the PSSC reports (1975 and 1977) and numerous other studies. Peace et al. (1982) maintain that this has resulted in conflicting demands on staff and the residential service: to cope with

increasing numbers of very frail dependent people who are seen by society in negative terms as burdens, at the same time as working with them in a way which asserts their rights as human beings.

This then is the history of residential care for elderly people from the feudal paternalism of 1601 to the contested 'new individualism' of the 1980's. It is in the context of the present, however, that this study is based, and it is recognised that, like most others, it is not morally neutral. Central to this research is the assertion that people, however elderly and frail, and whatever their financial status have a right to be treated with dignity and respect; to retain the ability to make choices insofar as they are able; and to participate in making decisions about how they live. The present political and economic climates may make this more difficult to achieve, but, given their physical and mental vulnerability, it is even more important to ensure that care practices enhance residents' dignity and autonomy and do not in themselves engender institutional dependence.

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CHAPTER 2

ALTERNATIVES TO TOTAL INSTITUTIONS:

A REVIEW OF THE LITERATURE

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2.1 TOTAL INSTITUTIONS AND INSTITUTIONALISATION

Goffman's work on total institutions (1961) is an important starting point for any study of dependence in elderly persons' homes. Nevertheless the concept must be used with some caution in relation to such residential establishments, since it carries with it negative connotations. Total institutions tend to be seen as bad per se, although the example of the ship (Aubert 1968) demonstrates that this need not be so. Rowlings (1981) suggests that the stereotypical view of an elderly persons' home as a total institution may result in the care provided in such settings being seen as, "a last resort and not a resource with its own particular merits." Again she says, "...this ... may divert energy primarily towards avoiding care and not on developing environments and care regimes which would raise the standard of care that is currently offered in many establishments."

The dilemma, then, is how to harness the usefulness of Goffman's work, whilst avoiding using the term evaluatively. It is important to remember that the concept of total institution is an ideal type and, as such, is unlikely to exist in practice in its pure form. Max Weber introduced the concept of ideal type; Gerth and Mills (1948), writing about his work, describe it as, "the construction of certain elements of reality into a logically precise

conception." They point out that the word 'ideal' has nothing to do with evaluations and that for analytical purposes one could as well construct an ideal type of prostitution as of religious leadership. Weber saw ideal types as "logically controlled and unambiguous conceptions ... removed from historical reality"; in other words as extremes or pure forms against which he could measure reality.

Jones and Fowles (1984, p. 200) in an analysis of the literature on institutions conclude that despite differences of definition, all writers, including Goffman, stress the following factors:-

loss of liberty
social stigma
loss of autonomy
depersonalisation
low material standards

One definition of a total institution, for example, that is widely employed is an establishment where all or most of the needs of the in-mates, whether physical, emotional, mental or spiritual, are met or controlled by the institution. Institutionalisation can be seen as the process by which an individual comes to be dependent on the institution and its ways, or as Goffman puts it, "an extreme form of socialisation." Total institutions he says, "are forcing houses for changing persons; each is a natural experiment on what can be done to the self."

The totality of such institutions is often symbolised by barriers to communication with the outside world. In addition Goffman (op cit) suggests four common characteristics of total institutions, although he points out that they are not peculiar to them. Firstly all aspects of life are conducted in the same place under the same authority. Secondly all in-mates are treated alike and are required to undertake daily tasks together. Thirdly the day's activities are tightly scheduled with the sequence of events determined by rules laid down by staff. Fourthly the activities are incorporated into a single rational plan which constitutes the aim of the institution. It follows from such characteristics that there will be clear distinctions between staff and in-mates and that the culture within the institution will be very different from that outside. Indeed contact with the wider community may be banned, rationed or made exceedingly difficult. In addition in order that in-mates be made to conform to the norms of the total institution Goffman's "extreme form of socialisation" is necessary. Typically this involves a mortification process in which the newcomer is stripped of his/her identity and culture in order to learn how to conform to the expectations of the new role of in-mate.

Clearly power is an important aspect of life within total institutions. Lukes (1974, page 34), for example, defines power as, "A exercising power over B when A affects B in a manner contrary to B's interests." Within institutions power is unequally distributed,

with staff having a great deal and in-mates very little. Arguably, the more total an institution and the more disabled the in-mates, the fewer the checks on the staff's power over even very basic aspects of the in-mates' daily lives, and the more likely it is to be abused, or in Luke's terms, used against the residents' interests.

These characteristics do indeed sound exceedingly harsh when considered in relation to elderly persons' homes, and it must be remembered that they are characteristics of an ideal type, not reality. Nonetheless they are helpful in identifying those aspects of residential provision which are institutionalising. Elderly people's homes are not built with barriers to the outside world like prison walls, but older ones are often at the end of long drives and newer ones are often far from town centres or surrounded by other non-domestic buildings. Many aspects of life in a home are conducted in the same place, the lounge or dining room, under the authority of the staff. In some homes residents continue to be treated alike for fear of allegations of unfairness; and in most homes eating and sometimes sleeping is perforce undertaken communally. In many homes activities are tightly scheduled usually around meal times, which are, like bedtimes, determined by staff. And almost all of these activities and many more can be rationalised in terms of their being for the residents' good. There are often very clear distinctions between staff and residents, characterised by separate facilities

and by the respective forms of address used to name but two. Whilst contact with the outside world is not banned as such, the location of many homes may discourage outings and visitors and the home itself may well be perceived as unwelcoming. A notice by the door bell of one establishment which read, "Visitors will ring the bell before entering" is well remembered. Finally, in relation to mortification processes, whilst not on the same scale as initiation ceremonies reported in some public schools, old people are often routinely divested of pension books and medication on admission and many ordinary everyday activities, such as having a cup of tea when you want to, are sometimes discouraged.

It can be seen, therefore, that residential homes for elderly people do have some characteristics which correspond with total institutions. Equally they have many which do not, and in this context, Smith (1970, 1979) provides a helpful construct when he suggests a polar type to the total institution which he names the permeable organisation. The latter is characterised by voluntary membership; clear divisions between and a choice in various daily aspects of living; an informal and relatively ambiguous status division between staff and residents; and an aggregation process, instead of a mortification process, in which the inmate's previous identity and culture is welcomed and encouraged within the new setting. There are, therefore, few barriers between the organisation and the wider community since the cultures and their norms and values are similar.

Thus it is possible to envisage a continuum with the total institution at one end, the permeable organisation at the other (see Table 2.1) and most residential establishments somewhere between the two according to their characteristics.

It is clear that in recent years elderly persons' homes have moved some way towards the permeable organisation: residents are no longer known by number or all dressed alike; more single rooms or bed-sits encourage privacy; some limited choice is sometimes given about meals; some elderly people do retain their pension books and medication; and increasingly residents are invited to participate in the running of some aspects of the home. Such developments have been well documented by many commentators, for example Marston and Gupta (1979), Willcocks, Peace and Kellahar (1982) and Evans, Hughes and Williams with Jolley (1981) all describe elements of what is currently held to be good practice in their analyses of residential care. Nevertheless other practices can be seen to be nearer the total institution end of the continuum: most old people have their money affairs handled for them as a matter of course and are left with 'pocket money'; many separate rules and facilities for staff and residents symbolise status differences between them; large communal lounges and dormitories do still exist and elderly people continue to feel uninvolved in decisions made about them. It is interesting to note that at least some of these characteristics are institutionalised by D.H.S.S. regulations. For example, the D.H.S.S., in

Table 2.1 Total Institution and Permeable Organisation Continua

TOTAL INSTITUTION	PERMEABLE ORGANISATION
1. Attendance compulsory.	Membership voluntary.
2. No barriers between sleep, work and play. Activities tightly scheduled; occur in one place within single plan (staff-given).	Clear division between sleep, own activity, domestic arrangements. Residents decide own activities.
3. Membership excludes other relationships and memberships: symbolised by physical barriers.	Membership places few restrictions on other social networks.
4. Clear distinction between staff and clients; no mobility possible. Staff control information and decisions about clients.	Relative status ambiguous; division of labour moves; information shared.
5. Mortification process:- stripping away from old identity/culture in order to learn new role. May involve loss of name, clothes, belongings.	Aggregation process - own identity/ culture is welcomed and encouraged and own view of organisation is tolerated.
Barriers between institution and outside society and therefore between in-mates and outsiders. Distinctive culture emerges. Institutionalisation likely.	Few barriers between organisation and society. Culture of two very similar. Client retains own culture and identity.

addition to prescribing sizes of rooms, also has rules relating to 'pocket money', although it is referred to in the literature by the less infantilising term 'personal allowance'. This small amount of money has its origins in the fact that Part III accommodation is subsidised but that official recognition is given to the need for 'money to spend as they wish, for example on stationary, personal toiletries, treats and small presents.' The amount is fixed at about one fifth of the basic pension. (D.H.S.S. 1978).

It can be seen, then, that whilst residential establishments for elderly people do not constitute total institutions in their pure form, institutionalising features and practices are still fairly widespread. Brody (1977) maintains that the dependency and passivity engendered by trying to fit people to institutions rather than the reverse 'are among the best documented findings in gerontology.'

Goffman (1961) suggests four different types of adaptations to total institutions: firstly withdrawal from the institution and its people; secondly intransigence, when the in-mates resist the attempts of the institution to make them conform; thirdly colonisation, where the environment is manipulated for the benefit of the in-mate; and lastly conversion where in-mates accept the institution's view of them and seek to become perfect in-mates. In addition to these four types of adaptation, it has been suggested that inherent in a total institution are social problems which

stem from underlying structural features rather than from the personalities of the people working in them. This is an important point if one is to avoid blaming hard-working and often dedicated staff and to concentrate instead on trying to understand what happens.

Smith (1970, 1979) suggests three such important structural characteristics. Firstly total institutions produce 'harsh even violent' behaviour, which can be explained as part of the mortification process. This can take the form of active violence, or what Brearley (1977) calls passive or structural violence, which he defines as, "that which creates a gap between what an individual needs (which demands a concept of human rights) and that which he is able to obtain." Thus he sees regimentation, depersonalisation and role deprivation as structural manifestations of passive violence.

Secondly Smith suggests institutions bring about self fulfilling prophecies. That is that the institution itself engenders behaviour that is seen as proof of the need for care. Barton's classic work on institutional neurosis (1959) illustrates this phenomenon in its extreme form in mental hospitals. It is characterised by 'apathy, loss of interest, lack of initiative and sometimes a characteristic posture and gait.' Successive studies and personal experience confirm that such behaviour is also apparent, perhaps in less extreme forms, in many elderly persons' homes.

Thirdly, the impermeable and isolating nature of total institutions encourages behaviour which is different from outside. Thus the very nature of the institution makes rehabilitation or normalisation (often its stated aims) difficult to achieve. This danger has been recognised in some homes which have been reorganised into several smaller groups in which people live on a more domestic scale. See for example Marston and Gupta (1979).

In short a total institution has structural characteristics which tend to encourage dependence rather than independence. Ward (1980) points out that "it is not so much the nature of the people working in residential institutions which can result in inappropriate treatment as the expectation of their behaviour which they infer, either from the system within which they work, or from the wider society." Ward quotes as evidence for this point of view to the prison role simulation of Zimbardo (1971) and Milgram's obedience experiments (Milgram 1961). Both showed how role expectations could enable people to act in ways which they themselves saw as inhumane. Thus he argues that "the role played by the more senior staff is very important in determining the type of environment created." This notion that individual staff attitudes may be less important to the quality of care given than the regime, is echoed by Davies and Knapp (1981) who say "the pressure of social environment often seems to overwhelm personality as a determinant of behaviour."

So far an examination of the concept of total institution, its

usefulness and limitations, has been given, together with an analysis of the process of institutionalisation. It has been argued that, whilst accepting that total institution is an ideal type, it is of use in a comparative way, especially in relation to its polar opposite the permeable organisation, in examining practices in elderly people's homes. It is now proposed to review the literature to examine what are thought to be the causes of institutional dependence and then to look at ways suggested to improve matters.

2.2 INSTITUTIONAL DEPENDENCE: THE ROLE OF THE ENVIRONMENT

Dependence, like institution, is a word which carries with it negative connotations. Yet dependence, interdependence and independence are features of everyday life, the mix being determined by such factors as life stage, personality, disability, economic status and role. There is nothing intrinsically wrong about dependence: indeed to allow ourselves to be appropriately dependent may well contribute to our mental health and at certain stages in life, dependence may be essential for even physical survival.

Brody (1977) clarifies the issue somewhat when she differentiates between 'normal' dependence in old age and dependence that is fostered by the environment. It is the latter that is of concern: the role that the environment itself plays in encouraging dependence in an old people's home. As Gottesman and Brody (1975) put it, "a gap is known to exist between the actual physical, mental, functional and social conditions of institutional residents and

their potential. The gap is attributable in part to the characteristics and experiences of the population, to the dramatic and traumatic change in one's life that institutionalisation represents, and to the nature of institutional care."

It is important, however, not to attribute the cause of any deterioration solely to the nature of the institution. As the above quotation suggests, and as Kasl (1972) points out more clearly in relation to mortality rates, the present state of research can only demonstrate correlations between living in an institution and deterioration of various kinds. The causes of such deterioration may be in the nature of the institutional environment, but they may equally be found in the characteristics of the individual residents or in the experience of the move itself. Nevertheless, whilst we may not be able to do much about the personalities and past experiences of residents, admission procedures and care regimes can be examined and modified.

A review of the literature, both British and American, reveals more detail of the nature of admissions and institutional environments themselves which are currently thought to encourage dependence.

In relation firstly to admissions Kasl (1972) in a review of the literature concludes that those which are badly planned, result in the loss of existing social networks and do not involve the prospective resident in the decision making or preparation for the move, have most deleterious effects on people. Brody (1977)

maintains that such effects are worsened when the person is ill, depressed or disorientated at the time of the move. Sadly these characteristics still apply to many old people coming into a residential home. It is often argued for example by Smith (1979), that admission to elderly people's homes is voluntary, in the main, and that this is one aspect of such establishments which differentiates them from total institutions, which are characterised by compulsory admissions. However, the research seems to indicate that whilst admission is legally voluntary, except in rare circumstances,in practice it feels involuntary to the residents themselves. Decisions are often made for them and the studies further demonstrate that when this is the case the likelihood of negative outcomes is increased, see for example PSSC (1977, page 23) and Brearley (1980, page 164).

Turning to institutional environments themselves, Whitehead (1970) suggests that authoritarian regimes, lack of satisfactorily motivated staff and poorly trained staff ignorant of the emotional needs of old people are the main causes of dependence. Whilst this may be descriptively true of some establishments, it does seem to fall into the trap that Smith (1979) warns about of blaming staff rather than attempting to understand what happens.

Another earlier writer, Barton (1959) suggests some similar causes like the bossiness of staff and the atmosphere, but also other factors such as loss of contact with the outside world, loss of

personal friends, possessions and personal events and enforced idleness. These later factors bear more resemblance to "the traumatic change ... that institutionalisation represents and to the nature of institutional care" that Gottesman and Brody describe above. A further factor put forward by Barton is the use of drugs. This is still an area of concern today, as it is only slowly being recognised that drugs, especially those not reviewed regularly, may cause the dependent behaviour which is often treated with yet more medication.

In a fascinating article entitled 'The infantilisation of the elderly' Gresham (1976) shows the importance of attitudes towards elderly people. She maintains that elderly people are often treated like children in a patronising manner which diminishes their self worth, "causing them to want to do less for themselves which makes them more helpless and childlike." Like Goffman, Gresham sees this as part of the socialisation process which takes place within institutions, "the proposition is that an essential part of the infantilisation of the elderly is a socialisation process" in which the person is encouraged to adopt behaviour appropriate to the new role of in-mate. Invariably this behaviour is that which makes for the smooth running of the establishment.

Bennett and Eisdorfer (1975) develop this theme when they describe how dependency can be fostered by psycho-social environments as well as physical ones. For example, attitudes and practices like

treating everyone alike in the name of efficiency and safety can result all too easily in under-achievement. They point out that few establishments 'permit' the maintenance of skills which are an integral part of non-institutional life, such as cooking and housekeeping, thus fostering passivity.

Brody (1977) similarly states, "services that enable old people to improve their functioning are not 'over-service'. On the other hand dependency is fostered by the over provision of services in the interests of the provider, as when the institutionalised elderly are fed and dressed routinely because it is less demanding of staff than encouragement of self care." This routine over-provision results in a loss of power over one's own life which, in addition to the loss of previous home and role, encourages dependence. It is important to remember that all old people admitted to residential care have suffered multiple loss. Often admission follows the death of a spouse, but even when this is not the case, there is loss of home, life-style, neighbourhood, role, possessions and possibly pets (see Brearley, 1980, page 153).

Running throughout almost all these pieces of research is the notion that somehow the problem is inherent within institutions: that institutions themselves cause behaviours which are problematic and result in depersonalisation. In a powerful statement, Brody (1973) calls these behaviours iatrogenic diseases, that is caused by the treatment (of coming into care) itself. They are:

> "dependency; depersonalisation; low self esteem; lack of occupation or fruitful use of time; geographic and social distance from family and friends and cultural milieu; inflexibility of routines and menues; loneliness, lack of privacy, identity, own clothing, possessions and furniture; lack of freedom; desexualisation and infantilisation; crowded conditions; and negative disrespectful or belittling staff attitudes."

Later, echoing this theme, Brody (1977) says, "approaches that try to tailor the people to the institution, rather than the reverse, engender institutional neuroses. The resultant passivity, depression, less competent behaviour, infantalisation, desexualisation, low self esteem, submissiveness, anxiety and other indicators of poor adjustment and dependency are among the best documented findings in gerontology."

2.3 TOWARDS AN IMPROVED INSTITUTIONAL ENVIRONMENT

The suggested causes of institutional dependence then, have been explored and appear in the main to support the view of Brearley (1977), Smith (1979) and others that generally they go beyond the attitudes of individual members of staff and that they are in some way inherent in the structure of the institution. Nevertheless, alternative structures and regimes are possible and it is proposed now to examine ways in which it has been suggested matters can be improved.

The first area to consider is admission procedures. Kasl (1972) in his review of the literature concludes that the evidence is clear that preparation is of vital importance. Where people are prepared emotionally and mentally for a move they are less likely

to suffer mental and physical ill-health after admission. He also finds that the maintenance of previous social networks is important as is also the retention of as many possessions as possible. In a study of the effects of relocation or change of environment, Brody (1977) concludes that the most harmful effects were on those who were physically ill, depressed, confused or disorientated at the time of the move and those who were moved involuntarily. However, like Kasl and Brearley (1980), she stresses the importance of preparation: when people were involved in making the decision and planning the move, the deleterious effects were reduced considerably. These findings clearly correlate with Smith's notion of the aggregation process and it is heartening to see such practices increasing in many old peoples' homes. Willcocks et al. (1982, page 196) also stress the importance of people's participation in the admission process, suggesting that certain reasons for admission may be easier to come to terms with than others. "There is a strong association between reasons for admission and successful adjustment insofar as participating factors which are devoid of stigma or social rejection are more likely to allow residents to define and control the process of admission". Thus the realisation, on the part of the resident himself or herself that he or she can no longer cope is more likely to result in a successful admission than a breakdown in family relations leading to rejection of the old person.

In the context of admissions, the importance of expectations must be stressed. Far too often realistic accounts of what might be

expected are not given to prospective residents, many of whose ideas about residential care stem from the workhouse era. Once admitted, there tends to be an assumption by residents and staff alike that the resident will have to adapt to the culture of the home, rather than a realistic appraisal of what help the individual resident might want and what she might retain to do herself. Clough (1981) says, "there was abundant evidence ... that expectations played a significant part in the way residents behaved."

Turning away from admissions to the institutional environment itself, Bennett and Eisdorfer (1975) maintain that "detrimental effects of institutional life can be mitigated with appropriate environmental alteration and by adequate training of staff." A review of the literature on this subject suggests three crucial areas for potential improvement: the recognition of the individuality of the resident; the ways the staff, particularly the senior staff, approach their work; and contact with the outside world. Additionally, it seems that implicit in these studies, and explicit in a few, is the notion of elderly people's rights which go some way towards constituting a philosophy of residential care. Brearley (1977) for example, maintains that elderly people have the right to retain their independence and individuality; to appropriate accommodation; to respect and dignity; to be different; and to privacy. Echoing the central importance of rights, Clark with Asquith(1985) in an excellent chapter on Rights, Self determination, Paternalism and Authority, maintain that rights for residents

can be divided into rights which originate from respect for persons, such as the right to self determination and the right to be treated as unique, and those rights which come about as a result of being a resident, the right to receive a professional competent service for example. They suggest that the respect for persons rights is qualified when their exercise adversely affects others to an unacceptable degree, when the person is acting unlawfully or immorally and when the person's own interests are damaged. These qualifications emphasise the relationship between self determination and social control: it is the staff who determine the areas in which self determination is allowed.

Clough (1981) suggests there are 'core elements' which must be taken into account when considering old people's ways of living, "the very old are adults, with a right to choose, a right to privacy and a right to be helped." He continues, "It is on these firm foundations that practice must be built." Few would disagree with these sentiments. As Utting (1977) says, "intellectual assent (to the values of the caring professions) is easily given, but the difficult thing is to maintain such values through the practice of care." Nevertheless such statements of intent are important starting points and may, as Clough suggests, be seen as foundations on which to base practice, and to consider the three areas of possible improvement to residential care suggested above.

The first area was that of <u>the recognition of the individuality</u>

of each resident. This themeruns throughout the literature and is the one most frequently mentioned. Ward (1980) for example, advocates expanding individual choice and reducing an all-pervading service to one which meets individual need. This may be in relation to bathing, dressing, meal times, getting up and so on. This theme is taken up by Sherwood (1975) when she advocates a 'better fit' between the individual's needs and the services provided. Gottesman and Brody (1975) also stress the need to individualise care by reducing the size of institutions, mixing different types of residents, using key workers and encouraging residents to share responsibility for some aspects of life in the home. Clough (1981) expands this idea to maintain that the very function of a residential home for elderly people is to "provide a living base in which basic needs are met in a way which allows the individual maximum potential for mastery." Ward (1980) in an excellent summary of the literature, suggests that this is best achieved "in an environment modelled on the domestic household" in which there are maximum opportunities for individuals to do things for themselves, make decisions and maintain their identities. Ward sets great store by a 'domestic' or 'home-like' environment and whilst at one level it is obvious that he is wanting to move away from the characteristics of large impersonal institutions, it is a term to be used with caution. Our systematic knowledge of what domestic life means for very old people is limited, but what evidence there is suggests there are some features that we should not wish to emulate in residential

establishments. For example Audrey Hunt (1978) found that 30% of elderly people had unheated bedrooms; that 25% lived alone; that 66% had no telephone and that 12% of bedfast people neither received visits from nor made visits to friends or relatives. The term 'home-like' is like the word 'family'. We assume it must be good per se: it need not be. Nevertheless Ward argues that in such environments modelled on the domestic scale, it is possible to provide alternative role opportunities to compensate for the role loss inherent in coming into care.

The second area of potential improvement is in relation to staff. Ward (1980) says, "the weight of evidence is that in general people, in no matter what state, respond better (become more normal) in an environment which imitates the norms of the wider society rather than institutional norms." Thus the staff, particularly the senior staff, have a responsibility to encourage a 'normal domestic environment' which is resident - rather than institution-oriented. This has many implications for staff roles and staff/resident contact. As Clough (1981) says, the task is "both complex and skilful." For him the task for staff is "to encourage the individual to decide how she wants to live." This seemingly simple statement does indeed recognise the individuality of the resident and the responsibility of the establishment to meet the needs of individuials, but its implications for staff practice are enormous. Firstly as Clough reminds us we would need to listen to what elderly people say about their lives and what they want.

Only then would we understand sufficiently to be able to provide appropriate care. At present, the normative structure of the home exerts too much pressure for such individualised treatment to ensue. In order to lessen the power of the norms of the establishment, Clough suggests staff need to encourage their often physically dependent residents to be as emotionally independent as possible. This sometimes conflicts with staff's own needs to provide 'good care' which to them may often mean care that encourages emotional and physical dependence.

If such individualised care is to be given it requires accurate assessment. Goldberg and Connelly (1982) maintain that quality of care is a flexible construct based on "the accurate assessment of capacity for self care, social and emotional needs and expectations of the elderly resident, the living arrangements available which most closely fit the residents' capacities, needs and expectations ... and the skills and attitudes of the staff."

Having assessed need, several writers refer to the importance of individualised programmes which "support remaining functions and capitalise on existing strengths." (Gottesman and Brody 1975). This view is supported by Gresham (1976) whos says, "optimum growth and adaptation can occur all along the life cycle when the individual's strengths and potentialities are recognised, reinforced and encouraged by the environment in which he lives." Such individualised care programmes are still rare in elderly

persons' homes, yet appear to be successful when they are used and based on realistic objectives. However, research suggests that intervention needs to be sustained if the improvement is to be maintained. When intervention stops any change in capacity tends not to last. This is seen not to indicate failure, but rather "the chronicity of the defects of the institutionalised elderly." (Gottesman and Brody 1975).

Assessment and individualised care programmes require social records, as well as the more usual medical ones to be kept, so that reviews can monitor the original assessment and intervention and in turn lead to modified future programmes. Again such records are rare in elderly people's homes, but are on the increase.

The task is indeed 'complex and skilful'. So far it has been suggested that staff need to listen to residents, and, together with them if possible, to assess their capacities, to devise programmes to enhance or maintain those abilities and to monitor their achievements. It is generally assumed that staff training is vitally important and certainly the suggestions above to improve the quality of residential care would appear to support this view. However it has to be said that Davies and Knapp (1981) were able to find very little empirical evidence to show that training improved the quality of care provided. Despite this lack of evidence a general consensus, described by Goldberg and Connelly (1982) does exist that training, especially of senior staff, is

beneficial. This view is supported by the evidence, referred to earlier which suggests that it is the attitudes of the very senior staff which are crucial in determining the climate in the home and the quality of the service provided. "Numerous studies ... have identified management ideologies as key variables characterising the institution and often largely determining patterns of treatment and care." (Evans et al. 1981). They continue, "Effective management of the social environment in institutional settings is by no means easy ... whilst ... good intentions on the part of the staff and a willingness to talk to residents are desirable, they are insufficient to guarantee a satisfactory social environment. A knowledge of how to create an environment which encourages the formation of friendships, independence and self determination and which fosters interests, activities and participation in collective decision making is essential. Resident committees and regular activities are part of such developments but must be seen in broader contexts of a shift in institutional ideologies in the direction of more resident oriented practices, and their effects should be assessed in terms of overall indices of the quality of the environment." It is in this context that training is seen to be important for senior staff in residential establishments.

Another contentious area relates to staff/resident communication. Again it has been assumed that such contact is good. Indeed Brearley (1977) puts it at the top of his list of prescriptions

for improving institutionalised conflict and violence. However, the empirical evidence is less clear cut. Some research, for example the study of six residential establishments in Manchester, referred to above, (Evans et al. 1981) demonstrated that most talk between staff and residents was instrumental and thus not likely to enhance the likelihood of a resident oriented regime if it were increased. Lipman and Slater (1977) go so far as to advocate discouraging staff/resident contact by physically distancing their respective facilities; it being argued that this would help discourage dependence on staff and encourage self- and mutual-help amongst the residents. Clearly more research is needed in this area, but what does seem indisputable is that it is the quality of communication that is important, not just its quantity.

This is equally true of course in relation to staff/staff communication as it is in relation to staff and residents. Evans et al. (op cit) found that this was a crucial area in determining the regime of an establishment. They found that the officer in charge's commitment to a resident oriented regime was vitally important but that it had to be accompanied by a leadership style and communication skills with the staff which enabled her to translate commitment into practice. Homes which were relatively successful in this respect were characterised by generally positive relationships between staff; high degrees of consultation and communication and a general agreement amongst them about the values on which the practices within the homes were based. This led in one home

to a staff decision to sit with the residents and talk socially to them for an hour before supper each evening.

Thus far the argument has centred on the social environment of elderly persons' homes, and this is the primary focus of this work. However several writers, Evans et al. (1981) and Marston and Gupta (1979) for example, refer to the importance of the physical environment insofar as it affects the social environment. In particular they examine seating arrangements and how they affect communication and engagement levels. Often chairs in lounges are arranged in straight rows around the walls, which,not surprisingly, was found not to be conducive to high levels of contact between people. Smaller numbers of chairs grouped in circles or semi circles around a focal point were found to increase levels of both communication and engagement, and this was thought to be valuable. Although it was recognised that not all the ensuring interactions were necessarily positive, Evans and his colleagues in particular stated a belief in the positive value of engagement. It is argued by many writers that engagement, that is interaction with people or materials, usually results in greater healthiness and happiness. Other writers, however, notably Cummings and Henry (1961), talk about disengagement, which is seen as the natural process in old age of disengaging from life. Such theories have led to such diverse practices as enforced group activity on the one hand, to staff being told to leave people to sleep or doze all day on the other. Evans et al. (op cit) explicitly reject disengagement

theory and indeed several pieces of research, reviewed by Goldberg and Connelly (1982) suggest that providing opportunities for activities, in the guise of staff and/or materials, does result in significantly increased levels of activity, even when the staff later withdrew but left the materials.

Marlowe (1973) provides some empirical evidence about the sorts of institutional environments likely to result in improvement. One group of people was placed in an enriched environment and a control group in an ordinary environment. He found that the first group's performance improved, whilst the control group's did not. The environment of the improvers was characterised by firstly encouraging autonomy; secondly fostering personalisation; thirdly offering less succorance when people could help themselves; fourthly fostering community integration; fifthly lowering tolerance of deviance of what would normally be expected of people; sixthly encouraging social interaction and not expecting docility and passivity; and finally treating residents with warmth and positive attitudes. This study appears important since it does demonstrate 'the positive potential of institutional environments.' (E.M. Brody 1977).

The third main area for improvement suggested in the literature relates to contact with the outside world. It has already been shown that institutional dependence is less likely to occur if the institutional environment is as far as possible like the

domestic one. Smith's (1979) concept of the aggregation process suggests the importance of being able to take things from outside into the home; to be able to receive visitors; and to be able to maintain previous contacts outside after admission. These notions are confirmed by Brearley (1977) and Gottesman and Brody (1975) who also stress the importance of welcoming family visits, short term admissions and the use of volunteers from the community. Many old people on admission have already lost much of their previous social networks through death or incapacity, and indeed social isolation may even be one of the reasons for entry into care. Nevertheless studies do demonstrate the beneficial effects of encouraging those contacts that do still exist.

Thus far the argument presented has centred on aspects of the social and physical environment thought to improve the quality of life of the residents. At this point it is important to stress that the quality of the environment in itself does not necessarily increase the quality of life of the residents, although it may be a pre-requisite for it. Goldberg and Connelly (1982) "regard the non-regimented, non-routinised, socially stimulating, enabling residential environment as an input or precondition for the achievement of desirable outcomes in terms of residents' physical and social functioning and subjective wellbeing." They later summarise the aspects of the environment that are currently thought likely to affect residents' quality of life positively. These are:

1. flexibility of management practices;
2. individualisation and autonomy for residents;
3. opportunity for privacy;
4. opportunities for social stimulation;
5. communication and interaction with the outside world;
6. social interaction between staff and residents (in in addition to instrumental communication);
7. maximum delegation of decision-making to care staff and residents;
8. good communication channels between staff;
9. a minimum degree of specialisation of roles and tasks among staff.

Whilst more research is clearly needed to explore further the nature of the relationship between the quality of the environment and the quality of life, it does seem reasonable, given the present state of knowledge, to assume that there is some relationship between the two: to assume that if the environment is changed along the lines outlined above it is likely to have some beneficial effect on the quality of life of the residents. Willcocks et al. (1982) and Davies and Knapp (1981) both claim empirical support for the view that resident well-being is enhanced when "individual rights and freedoms are asserted." (Willcocks et al., op cit).

Nevertheless,Ward (1980), in addressing himself to this issue in a section entitled 'commitment versus empiricism', correctly points out that whilst empirical data on interventions and outcomes is important, it is not the complete answer, since "commitment to change is also based on value judgements regarding the desirability of treating residents as normal individuals having the same rights as any other citizens."

In summary, it would seem that there is no one regime or environment which would improve the quality of life of all residents. Rather we need to move towards a flexible regime in which the different individual needs of residents can be met; in other words to move towards what Evans et al. (1981) and others call a resident-oriented rather than an institution-oriented regime. Or as Goldberg and Connelly put it we need to aim towards "the fit between the individual characteristics and the social situation" rather than "prescriptive stereotypes." Willcocks et al. (1982, page 274) maintain, "We should aspire to no single standard old people's home .. there is a need to retain a flexible and imaginative approach to need that is not coloured by the pre-conceived notions of those who might be regarded as the residential professionals - specialists who may act in terms of a paradigm which has no meaning for the residential consumer."

It is important to remember in this context that people, despite being very old and in residential care, are individuals with

different needs. The discussion about institutional dependence and its reduction should not blind us to the fact that some people might want and need to be dependent, particularly as they approach the end of their lives. Striving officiously for independence may be as detrimental in this situation as fostering dependence is in others. Miller and Gwynne (1972) make this point strongly in relation to chronically sick younger people and the same is true for older people who may be dying. Finally, then, we return to the individual: his or her needs and the institution's task of attempting to meet them. Only then would we "enable old people ... to retain their dignity; to preserve their personal history; and to integrate their former years with a future which is not entirely constrained by institutional necessity." (Willcocks et al. 1982, page 276).

2.4 THE EVALUATION OF RESIDENTIAL ENVIRONMENTS

The preceding sections of this chapter outlining the current thinking upon ways of improving the institutional environment, provided some of the theoretical bases for the following stage of the research: a case study of intervention with the staff group of one elderly people's home with the aim of helping them to move towards more resident-oriented practices.

The literature review revealed many suggestions for improving the institutional environment, but few attempts to implement

these changes in practice. Of the few that have tried to translate theory into practice, for example Marston and Gupta's interesting work on the change from large to small group living in Northamptonshire homes (1979), most have not monitored the effects of the changes in any systematic way, relying on the subjective feelings and views of the participants for evaluation. In the group work literature too Nano McCaughan (1978) writes, "Although there are many accounts of group work practice ... the analysis of outcomes is either based on the group worker's subjective judgement or left for the reader to judge." It was hoped in this research to monitor more systematically any changes that occurred as a result of the intervention, in order to evaluate the effectiveness , or otherwise, of the work undertaken. Several instruments purporting to evaluate institutional environments were known to be in existence and it was proposed to examine these in detail, in order to choose an appropriate one which could be used both before and after the work with the staff group.

Goldberg and Connelly (1982), in their excellent chapter on residential care, show how the development of measures to evaluate institutional environments stems from the acceptance of the values implicit in Goffman's work on the dangers of the total institution. Thus the measures that have been developed have "been directed towards ... social and practical inputs designed to bring about ... resident oriented rather than institution-oriented regimes." They show that Goffman's (1961) characteristics of

total institutions led directly to measures such as those of King, Raynes and Tizard (1971) of in-mate management in homes for mentally handicapped children, and, on the other side of the Atlantic, of Pincus (1968) of residential environments for elderly people.

In his review of measures of the quality of residential environments, Ward (1980) lists only one instrument specifically designed for elderly persons' homes, the Homes for the Aged Description Questionnaire (H.D.Q.) devised by Pincus (1968) and mentioned above. Ward concludes, in relation to the H.D.Q., and other more general scales, "we feel the general principles underlying the scales would find very general acceptability both as methods of monitoring and as instruments for research purposes." Davies and Knapp (1980) confirm the validity and reliability of the H.D.Q. as an instrument, quoting tests undertaken by Pincus and Wood (1970).

The H.D.Q. thus seemed the most promising instrument available, but Goldberg and Connelly, writing two years later in 1982, described a more recent British tool designed to measure those dimensions currently thought to affect positively the institutional environment. This was the Analysis of Daily Practices schedule developed by Evans et al. (1981) which sets out to evaluate the environment in simple operational ways by asking a battery of questions about the daily practices within an establishment. It too draws on the

work of Goffman for inspiration and on the measure devised by King, Raynes and Tizard for a model.

The literature therefore appeared to offer two instruments in particular which seemed to meet the needs of this research project. The choice was thus between an American instrument designed in the 1960's which was generally regarded as reasonably valid and reliable, the H.D.Q. (Pincus 1968) and a more recent British tool, The Analysis of Daily Practices schedule (Evans et al. 1981). A detailed examination of each led to the decision to use the latter on the grounds of its relative simplicity, its being up to date and its being British and therefore likely to be culturally more appropriate for an English elderly person's home.

The Analysis of Daily Practices schedule "was developed to assess the extent to which a home had adopted resident-oriented or institutionally-oriented practices in relation to four key areas:

1. resident care
2. resident autonomy
3. staff/resident interaction, and
4. organisational practices and features."

(Evans et al. 1981). Each of these four areas comprises a section of the schedule and each section contains a number of questions, the answers to which are either yes or no. Each answer is given a code of 0 or 1; thus, on completion of the schedule, an overall

score for the home in relation to its institution/resident oriented-ness can be calculated, as well as four sub-totals for each of the sections listed above. A low score denotes a resident-oriented regime and a high score, maximum 78, an institution-oriented environment. The full schedule is included as Appendix 1.

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CHAPTER 3

THE ACTION RESEARCH: A CASE STUDY OF CHANGE

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3.1 INTRODUCTION: TOWARDS AN INTEGRATION OF THEORY AND PRACTICE

The relationship between theory and practice has always been problematic in the social services field: there is no magic fit between the two. Nonetheless many people, including the researcher, argue that an attempt at integration should be made.

Hardiker and Barker (1981) make a useful contribution to such attempts with their distinction between practice theory, which they define as social work's largely undocumented 'practice wisdom', and theories of practice which are derived from major sociological and psychological theories about people and their behaviour.

Lee (1982) develops these ideas further, arguing that the relationship between theory and practice is best conceptualised by distinguishing between:-

1. The accomplishment of the task.
2. The technical 'how to' knowledge, which shares many similarities with Hardiker and Barker's practice theories.
3. Theoretical knowledge which provides the understanding underlying the technical knowledge (theories of practice).

Thus he maintains that knowledge is multi-layered, some parts being closer to actual practice than others.

Lee (op cit) argues that whilst technical how-to knowledge may be

sufficient for a car mechanic to mend a car , without for example also having a theoretical understanding of the internal combustion engine, it is dangerous for social work tasks to be attempted with technical know-how alone. This is because such practice would ignore the ethical and political context in which it was being undertaken: the means or methods would become disassociated from the ends. Theories of practice explain why and how to use technical knowledge.

Because the social work task is so complex, there are many technical and theoretical disputes. It is for this reason that the questions of why and how are so important. Such theoretical perspectives are not value-free, they involve moral and political values which should, in Lee's view, be made explicit rather than being concealed. Inevitably this leads to the question of which theoretical approaches should inform and guide social work practice. Neither Lee (1982) nor Hardiker and Barker (1981) offer any easy answer. Inevitably tensions and conflicts exist between different theoretical perspectives in the social sciences, for example between psychoanalytic and behavioural psychology. Others may appear to have little immediate technical utility, for example the Marxist critique of social work as an activity which patches up intolerable situations instead of tackling the underlying structural problems of inequality. Nonetheless it is argued such tensions should be lived with and integration of the three levels should be attempted because technical knowledge alone is insufficient. In addition to arguing

that theoryless practice is potentially dangerous Lee also argues against the pursuit of theory which does not take into account the experience of practice: again the plea for integration.

Thus for example humanistic psychology offers an explanation of the nature of human nature. From this theoretical knowledge is derived more specific technical knowledge about the characteristics of a helping relationship and its attendant skills which in turn can inform and guide actual practice. At the same time the experience of the practice also informs the further development of technical knowledge and theory.

Such an analysis, though more complex, could also be made of the research undertaken in this project. The task was to help a group of staff move towards a more resident-oriented environment. The technical knowledge derived from personal experience or 'practice wisdom' included the notion of starting where people are, and the advantages of using experiential exercises to facilitate learning. The technical knowledge or practice theory included knowledge of group work and counselling skills and knowledge of leadership styles. Finally the theories of practice which underpinned the work comprised amongst others humanistic psychology, phenomenonological and interactionist sociology and the sociology of organisations.

Underlying the theoretical perspectives employed were certain

value/political positions including a particular approach to the nature of people. The task therefore was not morally neutral, but was rooted explicitly in theoretical assumptions which may be described in more detail as follows:

1. All people are of worth, irrespective of race, gender, class, age or impairment and therefore should be treated with respect.
2. Authoritarian forms of social organisation, in which few have power over many, deprive people of feelings of self worth and of their right to determine their own lives.
3. More egalitarian forms of social organisation in which power is more equally allocated enable people to retain as much self determination as possible (see for example Rogers 1978).
4. In enabling climates people will develop in ways which are both personally and socially constructive (see for example Rogers 1961).
5. The meaning attributed to any behaviour by the person/s involved is crucial to any understanding or explanation of that behaviour.
6. Such commitments inevitably affect both the way a situation is perceived as well as any intervention that is undertaken, and should therefore be made explicit.

The following sections, which include a description and analysis of the work undertaken with the staff of one elderly persons' home, tend to focus on technical knowledge and actual practice. Nevertheless the assumptive framework outlined above underpinned

the work and did to a considerable, if indirect, extent guide the research.

The material on institutional dependence described thus far in the literature review serves two purposes in relation to this stage of the research project. Firstly it has identified the practices that are likely to engender institutional dependence in elderly persons' homes and secondly it has summarised the strategies identified in the literature as being likely to bring about a more resident-oriented institutional environment. The former can be seen as the statement of the general problem and the latter provides suggestions of ways to overcome the problem, although there appear to be very few empirical studies to test these hypotheses in practice. In Lee's terms (1982) the sociology of institutions provides both a theory of practice, in that it explains how institutions work, and practice theory in that it suggests ways in which they can be improved.

The fieldwork in this research project, a case study of intervention with the staff team of one elderly persons' home, was designed to discover whether the practice theories were useful in practice. That is to see if it was possible to bring about changing practices within a relatively short period of time. To this end a range of theoretical and technical knowledge has been employed.

Perhaps the most useful way of conceptualising this complex activity is to see it as an intervention process: "a practice ... comprising a range of tasks that can be placed in a sequence that has a beginning, a middle and an ending ... a series of phases or steps ... Each phase has its own tasks that need to be carried out both by the worker and the group. In order to carry out these tasks the participants need to have or acquire certain kinds of knowledge, skills and technologies." (Henderson and Thomas 1980). They go on to say, "The accomplishment of the tasks at each phase of the process will largely be determined by the effectiveness of the strategies and tactics used by the worker and/or the group to carry out the tasks. It will also be affected by the resources ... and ... by the kind of role the worker chooses or is forced to play by the group."

Several process models have been formulated in the various fields of group work, social work, research, adult education and action research. Pincus and Minahan (1973) for example suggest a model for conceptualising essential social work practice skills, in which the following stages are identified:-

1. assessing problems
2. collecting data
3. making initial contacts
4. negotiating contracts
5. forming action systems
6. maintaining and co-ordinating action systems

7. exercising influence
8. terminating the change effort.

Knowles (1972) in the field of adult eduction, suggest the following phases:-

1. setting the physical and psychological climate
2. mutual planning
3. diagnosing needs
4. formulating programme objectives
5. planning a sequential design of learning activities
6. conducting the learning experiences
7. evaluating the learning.

Another process model, formulated by Lees (1975) in relation to action research comprises the following stages:-

1. an evaluation of a particular situation
2. a decision about what needs to be or can be improved
3. a strategy to bring about the improvement
4. an evaluation of the effectiveness of the action
5. a re-assessment of the situation with a view to modified action strategies if necessary.

Clearly there are similarities in all these process models, although the detail varies according to the focus of the writer.

It is proposed to present this work as a process, that is as a series of stages, each of which require the worker, that is in this case the researcher, to have particular areas of knowledge; posssess certain skills and perform certain tasks.

The process will be presented under the following headings, and will include discussion of the principles which guided practice during each stage:-

1. negotiation in principle with the social services department
2. selection of the home
3. negotiating a contract with the staff
4. the period of observation in the home
5. evaluation of the institutional environment
6. the work undertaken with the staff
7. re-evaluation of the institutional environment
8. analysis and evaluation of the effectiveness of the research group.

These stages can be seen to approximate to several of the process models described above, interestingly to the Pincus and Minahan approach in particular, which is presented as a generic and unitary model.

3.2 NEGOTIATION IN PRINCIPLE

Negotiating a contract, a relatively simple-sounding task, in reality took a long time. The initial contact with Wiltshire Social Services Department about agreement in principle to work with the staff of an elderly people's home in an attempt to change institutionalising practices was made in 1982. The research proposal to the university and the literature review followed

and more detailed negotiations started in the summer of 1983, and were completed in the autumn of that year.

Lees (1975) defines action research as, "a fluid relationship between researcher, worker and administration ... trying together to improve the effectiveness of the service." At this stage the contact was with the administration and the principles guiding the work were to communicate with the people in the organisation who could give permission for the project and who needed to know about it; to communicate clearly and concisely the planned nature of the project; to listen carefully to any reservations expressed; and to state clearly how the research would affect the organisation.

Communication and relationship building skills were thus required at this stage and these were facilitated by alreading existing good working relationships between the researcher and the senior staff in the department.

3.3 THE SELECTION OF THE HOME itself involved three separate stages: firstly setting the criteria for the selection; secondly drawing up a short list of possible homes from the selection criteria; and thirdly approaching the officer in charge and the staff of one home for permission to work with them. Since the project was to be a single case study, any attempt at arriving at a statistically representative home was out of the question.

Nevertheless it was hoped to find an establishment which might be described as typical of many local authority elderly people's homes.

Apart from this, the theoretical considerations which informed this part of the research came mainly from action research. Lees (1975) maintains that a successful outcome is more likely when a common value base exists between researcher and workers and where there is a prior agreement about objectives. Thus it was important that the staff of the home selected shared the researcher's values in believing that a move away from an environment characterised by institution oriented practices towards more resident oriented practices was a good thing. In addition they should want to change in that direction.

Another principle was that the relationship between the researcher and the staff should be as open and honest as possible and that the direction the action research took should be shared as far as possible. One implication of this was the necessity to be honest about the difficulties involved in the research as well as its more exciting and challenging aspects, "One aim of action research is to see whether activities do lead to the attainment of objectives. This cannot help but pose a threat." (Lees 1975).

The first task was to complete a list of criteria which would result in the choice of a home which was as far as possible typical

of residential homes for elderly people, with a staff team willing to change. These were:-

1. A 50 bedded home, since this was the norm in Wiltshire.
2. A home in which the officer in charge and/or the deputy were C.S.S. holders. This was chosen because it meant that a certain knowledge and attitudinal base-line could then be reasonably assumed.
3. The senior staff to be committed to the research and want to move towards more resident-oriented practices: it was important that aims were shared.
4. The staff team as a whole to agree to the research being undertaken.
5. A non-specialist home, for example not one specifically designed for elderly mentally infirm people.
6. A basic residential home, without a day centre, or one with a day centre that could easily be excluded from the research.
7. A standard purpose-built home, not an old converted home or a very new one based on the bed-sitting room principle.

The Assistant Director (Operations) and the researcher looked at the Wiltshire homes in the light of the selection criteria and a short list was drawn up in the summer of 1983.

This task was facilitated by having specific selection criteria, although even so it was necessary to interpret them flexibly on

occasion, for example including the home, finally chosen, with 53 beds, on the short list.

Permission was given to the researcher to approach the officer in charge of the home which came closest to meeting the selection criteria. This initial meeting with the officer in charge required the research project to be explained clearly and simply, whilst also pointing out as honestly as possible the tensions inherent in action research as a method insofar as it almost inevitably involves a perceived threat to the practitioners (see Lees above).

The proposal to the officer in charge was that the researcher would work with the staff to try to identify and then move away from practices seen as likely to promote institutional dependence. What this would entail, as far as the staff were concerned, if they agreed to participate in the research, was explained as a series of stages:-

1. A period of observation during which the researcher would gather information about the home, become familiar with its norms and begin to get to know its residents and staff.
2. An evaluation of the institutional environment. This would be achieved by administering the Analysis of Daily Practices Schedule devised by Evans et al. (1981) see appendix 1) which aims to judge how institution oriented an establishment is by way of a battery of questions

about the daily practices in the home. The highest score, 78, would denote an institution oriented regime and the lowest score, 0, a resident oriented environment (see Chapter 2, Section 2.4).

3. A series of fifteen weekly sessions with the staff, lasting approximately an hour, during which the group would decide which practices were likely to encourage institutional dependence and make decisions about how to change them where appropriate.
4. The administration of the Analysis of Daily Practices Schedule again three months after the completion of the work, in order to monitor any changes in the institutional environment.
5. The writing up of the research changing names and places.

These stages clearly refer to stages numbered 4 to 8 in the process of the fieldwork for the case study (page 74).

The officer in charge was initially positive about taking part in the project. She was relatively new to the establishment and wanted to move in the directions being suggested. Thus she saw the research as having the potential to help her achieve her own goals. This was reassuring since it meant that values were shared and objectives agreed upon (see Lees above). Nevertheless the importance of having the whole staff's approval for the project to go ahead was recognised. The officer in charge wanted to consult with her senior staff first before approaching the others and

it was agreed that she should do this and report back.

Towards the end of the interview a concrete example of how the group might operate, arising from the discussion of a problematic situation current in the home, seemed to bring the project alive far more than all the theoretical considerations. This was a timely reminder to start from where people are; a lesson which was constantly reinforced when the work with the staff began.

Within ten days the officer in charge had consulted her senior staff and gained their approval. She had also talked to the whole staff team who she said were 'quite enthusiastic' and wanted the researcher to address a full staff meeting to explain the project in more detail. The home was thereby selected and met many of the criteria laid down. It was a non-specialist home although it was in fact a 53 rather than a 50 bedded home and it did have an attached day centre. A decision to exclude the day centre from the research was made since it functioned fairly separately anyway. The officer in charge was a C.S.S. holder; the deputy and her husband, the fourth in charge, were untrained and had been in the work, and indeed this particular home, for many years. The third officer was C.Q.S.W. trained. Finally the staff generally had agreed to participate. The home, built some twenty years ago, was, and indeed still is, situated in a quiet residential area of a small but busy Wiltshire market town. The first impression was of a fairly traditional but warm and friendly home: very

much the 'typical' local authority home being sought.

3.4 NEGOTIATING A CONTRACT

Before a meeting with the staff could be arranged, many aspects of the contact had to be negotiated with the officer in charge, to be finalised at the meeting with the whole staff. Many of these negotiations centred around the group sessions themselves and subsequently the practice theory guiding this stage came largely from the group work literature.

Brown (1979) for example maintains that "research evidence and practice experience both testify that effectiveness or 'success' (however defined) are determined as much by what happens before the group comes into existence, as by what happens during the group's life." He also goes on to say that this stage requires "just as much creative energy, clear thinking and skills in communication" as the actual group meetings themselves.

Brown (op cit) argues that planning and preparation consists of three stages: firstly establishing that a need or problem exists and is shared by a number of people, and that a group is thought to be able to meet the need; secondly that there is organisational support for the group; and thirdly if the results are positive making decisions about membership, time, place and duration and negotiating a contract with the group members. Theoretically the problem and the need had been clearly demonstrated in the literature

review which showed that institutional environments do tend to engender institutional dependence. More specifically the need had also been seen to exist by the social services department and the officer in charge, both of whom were committed to change in the direction being proposed. What was less clear was whether a series of group meetings with the staff to work together on the problem would be the most effective way of bringing about change. Essentially this was the hypothesis being tested. Certainly there was research evidence which tended to support the idea in principle, and enough people were convinced that it was worth trying, including the staff themselves. This correlates with Brown's second stage, and includes the negotiations with the senior management of the department as well as the staff of the home itself. Having successfully negotiated the first two stages, the third involved planning the group itself; its membership, venue and so on.

Before turning to these detailed issues, it is worth noting the following: "a group is more likely to be successful if it is conducted in an instutional context in which other personnel, not directly involved with the group, nevertheless accept and support its aims and general procedures, and value its potential contribution to the shared goals of the institution." (Whitaker 1976, quoted in Brown 1979). Thus preparation to try to minimise the risk of sabotage by people unsympathetic to the group's aims was important. It was hoped to achieve this by involving people at every stage, consulting them, for example at the full staff

meeting, and explicitly giving them permission to ask about what was going on at any stage in the proceedings.

Group composition was the first of the detailed issues to be addressed. Redl (1951) developed an often quoted law of 'optimum distance' which states that group membership should be "homogeneous enough to ensure stability and heterogeneous enough to ensure vitality." This was clearly something to bear in mind when making decisions about who should be in the group. Another decision was whether the group should be open or clsed. It is argued that closed groups are possibly better for short term groups in that they provide stability. On the other hand a successful open group may maximise creativity.

Clearly all the people from whom the group could be selected, apart from the possibility of a new member of staff joining, already knew each other. Thus they were neither a 'natural' group, having come together by choice, nor a 'formed' group, only knowing one another in the context of the group, but rather an 'institutional' group, already in some relationship with one another. Brown (1979) maintains that there are advantages and disadvantages in this. The advantages are that the getting to know one another stage is unnecessary, and that positive existing relationships can be developed further. The disadvantages are that confidentiality can become a problem and that previously existing cliques can be brought into the group.

Group size was yet another issue to be considered at this stage. Brown (1979) suggests the optimum is 5-6 "small enough for participation and recognition, large enough for stimulation." This size is thought to be particularly appropriate for therapeutic groups, but for problem-solving groups a larger size may provide more resources and allow for the constructive use of sub-groups.

With these considerations from the group work literature in mind, it was necessary to make decisions about which of the staff in the home should be involved in the group sessions. There were clearly arguments in favour of including all staff in the research group, in terms of their involvement probably resulting in greater commitment to the changes decided upon and in terms of it enhancing the feeling of their working together as a team towards common goals. However there were also many arguments against this. Firstly it would mean a group size of well over twenty, far too many for the sort of participative group envisaged (see Brown above). Secondly there was the question of cost: no further staffing costs could be incurred by the project. In addition there was the problem of shift work and the various levels of conceptual ability of the staff. Another factor was whether the group should be open or closed in its membership. Hopefully the stability of membership a closed group would bring would encourage a faster pace of working ; on the other hand a closed group would exclude any new members of staff or those off sick at the beginning of the group.

Finally, in consultation with the officer in charge and her senior staff, a compromise was reached. In order to involve all staff as far as possible, so as to maximise commitment, the researcher would, as planned, address a full staff meeting, including the cooks, domestics, night staff, gardener/handyman and care staff. In addition records of each session would be written up and posted in the general staff room for everyone to see. The group membership for the majority of the sessions, would comprise the care staff only: that is the officer in charge, the deputy, the residential care officers and the care assistants. However when issues which affected other groups of staff were raised those people would be invited in. At this early stage it was envisaged that this might entail the night staff, the domestics and possibly the field social workers associated with the home and the kitchen staff within the home at various times. In terms of the core group itself it was decided to choose a time and day of the week which would maximise the number of people on duty. Others were free to come in their own time if they wished. The researcher favoured a closed group but the officer in charge particularly wanted a prospective new member of staff to be included, on the grounds that membership of the group would serve as additional induction into the ways of the home. This was agreed, as was the inclusion eventually of one member of staff who was absent on sick leave of several weeks' duration and so missed the first few group meetings. Thus it was hoped that everyone would feel involved and consulted about any proposed changes, at the same time as

ensuring that the group size was appropriate to its task. The resulting core group in terms of its heterogeneity (see Redl above) was certainly varied in terms of age, sex, education and training, social class and commitment to change. It was hoped that their common workplace and interest in elderly people would provide sufficient homogeneity. As a result of the decisions made about group composition, the actual group attendance varied in size from 7 to 13 and the mean attendance was 9.4. The times when the number exceeded the average were occasions when other staff were invited to attend. In all some nineteen staff attended, a few , mainly the night staff, for two or three sessions only, with a core of approximately eight who attended most times the group met.

Having resolved the membership of the group, the next decision to be made was the venue. Accommodation was the main resource to be obtained, since the officer in charge was happy for the staff to attend during work time. What was required was a relatively private room, yet within the home in case of emergency; a room with comfortable seating for the size of the group; adequate space to display flip chart paper on the walls; and a room conducive in atmosphere to the work being undertaken. There were three obvious possibilities: the office used by the officer in charge, the staff room and a small downstairs lounge. The office was rejected on the grounds that it was too small, formal and busy; the staff room was disliked by the officer in charge and

was thus rejected too. This left the small lounge on the ground floor. It was rarely used by residents, although turning out the one or two people who were sometimes there caused the researcher continual embarrassment and discomfort. The walls of the room could be used to display paper work if necessary, although clearly posters could not be left up from week to week. It was a pleasant room, of appropriate size, with easy chairs and, in general, proved a good venue which adequately met the needs of the group for a congenial environment and reasonable privacy.

Having decided on the group's membership and the most likely venue, issues about time, duration and frequency remained to be resolved. Brown (1979) maintains that these concerns must be determined by the resources available to the group and its purpose. The purpose was clear: to meet together with the staff team to make decisions about changing practice in the direction of more resident oriented practices. Time was thus needed to bring about such change effectively. On the other hand time was limited, both for the researcher and the staff in the amount of time they could spend away from the residents. Thus a proposal was made of fifteen weekly sessions each lasting an hour approximately. It was not envisaged that enormous changes would be effected in such a relatively short time, but that the timespan would be sufficient for significant change to begin and be evaluated. As Brown (1979) says, one must be "realistic and practical about the level of commitment and achievement that can reasonably be expected."

Even at this early stage it was envisaged that, if successful, the process could be continued by the staff after the researcher had left. Because Christmas is such a busy time in residential homes, a decision was made to have a break of three weeks in the middle of the series of meetings. In the event this proved useful in another way too, since it allowed the staff time to introduce changed early morning procedures in the early New Year. The day of the week, chosen to maximise the number of staff on duty, was to be normally Wednesday, but both the home and the researcher had occasional prior arrangements already booked for some of these days and so on several occasions the group met on Thursday instead. This meant that there were slightly different staff on duty, but since several came in their own time anyway it did not affect the group membership severely. It was decided at the suggestion of the officer in charge that the best time for the group would be 10.30 - 11.30. This meant that coffee was over before the group began, and lunch, at 12.00 noon, did not have to be postponed. In the event most sessions started about five minutes late and over-ran by approximately ten to fifteen minutes with the agreement of the group. This arrangement did not seem to cause undue inconvenience.

Leadership roles constituted another issue to be resolved at this stage. Brown (1979) describes leadership as "influence which is positive in a group-centred sense, that is which helps the group to work at its task, maintain itself in good working order and

adapt to its environment." By virtue of the proposal put to the home, the researcher had a designated leadership role in relation to the group sessions with the staff. The role of the officer in charge was less clear in this context. Clearly she was in a position of authority in relation to the other group members in line management terms, but she did not wish to adopt a prominent co-leadership role within the group. Thus the leadership of the group fell initially on the reseracher, although the support of the officer in charge was always apparent. It was hoped that as the group progressed the officer in charge and other group members would gain sufficient confidence and experience to take over or share the leadership where appropriate. One issue, relating to authority and leadership, which was fully discussed at this time, was how far the officer in charge was prepared to let decisions about practice be decided at group meetings, and conversely, to what extent she wished to retain her own authority to veto decisions or make different ones. Finally it was decided that the officer in charge would have to retain her right of veto, but that she would try to explain her reasons to the group should she have to use it. It says much for her open management style that, in the event, this right was never exercised during the life of the group, but it was probably an important issue on which to reach open agreement with the group. However an incident closely related to this issue did occur: at one point the question of care staff's access to residents' files was raised. It became apparent that the senior staff held different views on this. Rather than discuss

this publicly at the meeting with the staff, it was decided that they should have a senior staff meeting to decide a common policy and report back. This duly took place and a clear and agreed policy of access to the files ensued.

Apart from the staff, another group of people who clearly needed to be considered at this time were the residents. It was decided that the officer in charge would tell them individually or in small groups that the researcher, her ex C.S.S. tutor, was interested in the home and was going to be visiting quite often to do some work with the staff looking at how the home was run. This message was reinforced by the researcher during the observation period when appropriate. Several residents were quite interested,notably a retired headmistress in her nineties, but many others assumed the stranger was a new member of staff. The relative lack of interest probably reflected the absence of a strong tradition of involving residents in issues relating to the running of the home. A more resident oriented regime would, almost by definition, involve more resident participation and the researcher was tempted to get involved directly in trying to foster this with the residents. However, work with the residents was not part of the research proposal; rather the intention was to work with the staff to help them improve the quality of the environment.

Finally the format and content of the meeting with the full staff team was also negotiated at this time. The social services

officer, an adviser to the home, asked to be present at this meeting in order to demonstrate the department's support for the research project and this was much appreciated. It was decided that the researcher should outline the background to the research and the stages of it; explain the choice of the home; outline the draft programme for the group sessions and explain the reasons for the proposed composition of the group. At the end of this meeting a firm decision would be made by the staff about whether to continue with the research project, having heard what it would entail in some detail.

Negotiating and deciding upon the issues detailed above had involved the researcher, the officer in charge and occasionally the other senior staff in some considerable work together, and by this time the researcher was feeling positive about the relationship developing with the officer in charge. Both were excited at the prospect of the research, although sometimes daunted by the challenge also. The important issues seemed to be emerging and being faced honestly,with their implications being carefully thought through.

A draft programme for the group sessions had been drawn up and agreed with the officer in charge. The researcher had proposed that the first session consist of an examination of the values that should guide practice, resulting hopefully in a list that could be accepted by all the group and used in subsequent sessions to guide decision-making about changing practices within the home.

Beyond this first session the proposed programme was deliberately left flexible, consisting of a list of possible practice areas which could be examined if the group thought they were worthy of detailed consideration. The actual choice of topics and their order would be decided by the group and would thus reflect their priorities, not the researcher's, although clearly the researcher's values were reflected in the items chosen for the list. Nevertheless there was at least theoretical freedom for the group to add further items if they so wished. The practice areas suggested as possible topics for examination by the group were as follows:

admissions procedures

meal times

seating arrangements

resident participation in the running of the home

staff meetings and decision making

staff role specialisation

individualised care, including the key worker system

staff/resident communication

contact with other professional groups

contact with the community

early morning and late night procedures

evaluation of the group sessions.

In the event this list proved a useful starting point, but once the group started to examine one area, other important issues came up automatically and were dealt with or postponed for future examination as the group thought appropriate. A comparison of the original list and the actual content of the sessions shows

that almost all of the above subjects were discussed, although some only in passing. What the group decided was to concentrate on a few topics in detail, and in so doing many of the others arose as associated issues. It was realised that some of the possible topics, notably admissions procedures, might well involve other professional groups such as field workers from the local area office. It was decided that these would be legitimate areas to consider during the group sessions and that the researcher should visit the team leader to explain the project to her. She was interested in the plans for the group and very willing to consider, or be part of a group considering ways of improving admissions procedures, reviews of residents and so on.

The full staff meeting addressed by the researcher in October 1983, formally constituted the final part of the negotiation of a contract with the staff, since it was at this meeting that the decision to participate in the research was ratified by the full staff group. By this time the researcher had spent many hours researching the literature on institutional dependence, schedules to monitor institutional environments and action research. Suddenly she was faced with the task of explaining something of this complexity to a group of about twenty people, most of whom, at best, had only vague ideas about what the terms meant. The researcher was also very aware that the proposed work could well be seen as an implied criticism of the present regime in the home and that care needed to be taken in this area also

(see Lees 1975 above). On the other hand ten years' experience of teaching residential workers had shown that it was possible to translate complex ideas into something meaningful to people unfamiliar with their theoretical bases. The early work of J.S. Bruner (1960) on the spiral curriculum was useful in this context. He maintains that it is possible to teach almost any subject to people of whatever age, ability or achievement, provided one is prepared to "courteously translate" it for them. Thus the task of the researcher at this meeting was to courteously translate the research proposal and its background to a group of approximately twenty staff: domestics, care staff, cooks, night staff and the gardener/handyman.

After introductions to the group had been effected, the researcher explained how the research proposal had arisen from the combination of two separate interests, the belief in the importance of reducing institutional dependence and the desire to work with a team of people from one home. She also apologised in advance for possibly using technical terminology, explaining that she had been immersed in books on the subject for many months. This provided the opportunity to give permission explicitly for people to say if at any point they did not understand what was being said, or were worried about anything. However this is easier said than done for people totally unused to large group discussions.

Having explained how the idea of the research came about, the researcher outlined what had happened so far in terms of getting permission in principle from the social services department; reading and writing up what was currently thought to cause institutional dependence and ideas put forward of ways to reduce it; deciding what sort of home was required for the research and explaining how this particular home had been chosen; approaching the officer in charge for permission and thereby being at the meeting that day talking to all of the staff.

Non verbal signs, such as head nodding, smiles and the occasional frowns, suggested that the group was, in the main, interested in what was being said. However, important issues of concern had clearly been raised yet people were unable, initially, to air them in the big group, for fear, it transpired later, oif 'looking a fool.' Consequently buzz groups were used and this method successfully enabled people to discuss their fears and uncertainties, which they were then able to feed back to the total group where most could be easily resovled. One woman, for example, feared that the research would lead to changes that would force her to work more unsocial hours, which she was unable to do for domestic reasons. This sort of fear, of imposed change resulting in less congenial working conditions, appeared quite widespread and it was necessary to repeat several times and in different ways that any changes made would be decided upon by the staff team themselves, not imposed on them.

This in itself, the notion that a group of workers could make decisions about how to go about their jobs, was a new and novel idea to many and required careful elaboration and concrete example to illustrate it.

The next stage was to outline in more detail what the research would entail in relation to the home and its staff. This was presented as a series of stages:-

1. A period of observation in the home by the researcher.
2. Assessing the current institutional environment by means of the Analysis of Daily Practices Schedule.
3. The fifteen sessions with the care staff, plus other groups of staff where appropriate.
4. The administration of the schedule a second time three months after the completion of the group sessions, to identify any changes in the institutional environment and thus evaluate the effectiveness of the work.

Each of these stages required careful explanation of what each would entail. The most difficult was the instrument: it was necessary to explain that homes could be placed somewhere on a continuum, with institution-oriented homes on one hand and resident-oriented establishments on the other, and that the schedule enabled one to measure where any one home was on that continuum. This proved extremely difficult to put into comprehensible terms, but in the end a rather simplistic analogy with the sort of quizzes that purport to measure how sociable or

attractive to the opposite sex people are, shed some light on the subject.

The composition of the group and what would happen during group sessions were of obvious interest to the staff. In the main they seemed to agree with the decision to restrict membership to the care staff, at the same time welcoming the opportunity to participate if the issues being discussed involved them and their work. One exception was a kitchen domestic who could imagine no way in which what she did in the kitchen could affect residents' dependence and thus no point in her being involved in the group at any time. The social services officer at this point gave a perceptive example of how she might indeed be involved, at which the domestic nodded, looking thoughtful although still rather dubious.

Finally the researcher attempted to summarise the advantages and disadvantages of taking part in the research project and there was a general consensus that the process should continue.

In the main the officer in charge and the researcher were happy with the meeting. It seemed as if the methods employed, of a short talk by the researcher, illustrated by overhead projector transparencies, followed by buzz groups and a general discussion, had been successful. It also appeared that the decision to involve everyone as far as possible was a sound one, although even so

ambiguities remained in people's minds and some messages needed to be repeated several times, probably because staff fears made it hard for them to hear what was being said. The researcher remained unconvinced that she has explained the instrument adequately, but the officer in charge reassured her that the majority had understood and that she could reinforce what had been said to those who were still unclear.

Orford (1981) writes, "Those who have written of the 'action research' process talk of the importance of 'ownership' of the research activity. The aim is to get the unit's members fully involved and to make them feel the research is theirs." It was hoped, with some optimism, that the work undertaken thus far had succeeded in establishing the groundwork of this process.

3.5 THE PERIOD OF OBSERVATION WITHIN THE HOME

Orford (1981), describing action research, says, "After the initial approach there follows a period during which the action researcher gets to know the unit; usually by interviewing as many members as possible individually, by attending unit meetings, and by spending time in the unit observing." By the time the period of observation in the home began, the researcher had already met most of the staff at the full staff meeting described in the previous section; had had three long meetings with the officer in charge, during which time other members of staff

had sometimes been present, and had chatted briefly to some residents on entering and leaving the home.

Participant observation as a method is qualitative rather than quantitative and fits easily into the phenomenological tradition in sociology, which seeks to understand the detailed social reality of the actors in any situation. Its methodological strength is that it is the "best means of obtaining a valid picture of social reality" (Haralambos 1980). However, its opponents argue that observation is unsystematic and cannot be quantified or replicated and therefore the reliability of its data is questionable. This criticism notwithstanding, this stage of the research project was concerned with understanding the social reality of the people within the home and thus participant observation appeared to be the appropriate method to employ.

The role of observer is not unproblematic: in the absence of one way mirrors,observation within institutions cannot, even if it were desirable, be entirely non-participative. Worsley (1970) writes, "The rationale behind the use of observations in sociological research is that the sociologist should become party to a set of social actions sufficiently to be able to assess directly the social relationships involved. The degree of involvement may vary considerably from being merely a watcher on the sidelines to being deeply involved and part of what is going on." The very nature of action research involving researcher and workers in working together to improve practice, as well

as the personal values of the researcher, meant that participative observation was highly desirable and indeed essential. What was less clear was the nature and degree of that participation. Involvement and participation allow the researcher to "understand the meaning they (the actors) attribute to others, and so better to appreciate their behaviour. This gives ... a deeper insight into the behaviour of the people being studied." (Worsley 1970). On the other hand invovlement means the researcher is allocated a role with attendant obligations and expectations within the setting and this may affect his or her ability to gather information. For example on re-reading the records of the first visits to the home, the researcher was struck by the starkness of observations about the seating arrangements (around the walls) and some practices of the staff. Later, greater familiarity with the home and involvement with the people concerned reduced these striking observations to something approaching if not quite acceptance, certainly less obvious features of the institutional environment. Haralambos (1981)describes this as "dulling of the sharpness of observation."

The staff, and , theoretically, the residents knew why the researcher was present in the home at this time and in the main seemed to accept her presence and her varying degree of participation in what was going on. Haralambos (1980), however, quotes Whyte as saying, in relation to his classic participant observation study in 1955, "Acceptance in the district depended on the personal

relationships I developed far more than any explanations I might give ." This was confirmed by the researcher's experience: once personal relationships formed, acceptance and openness increased, almost irrespective, it seemed, of the most careful explanations for the research project given earlier at the full staff meeting. Worsley (op cit) maintains that when the observer's status is overt, "The people who have accepted him into their midst acknowledge his observer role, as well as any other role that he may have taken ... therefore he does have certain rights and a certain special degree of freedom at the same time." (Masculine pronoun used in the text). Thus when observing at meal times, the researcher adopted a worker's role and helped the staff distribute the plates to the residents. However, once the meal was completed she did not help with the clearing away and washing up since this did not involve the residents, but sat down at the tables to talk; a freedom the majority of the care staff, at least in their view, did not share.

In total the researcher spent almost fourteen hours in the home observing, over a period of about a fortnight, starting immediately after the full staff meeting. In an attempt to observe the majority of the waking day, she made six separate visits which together covered the life of the home from 7 am to 10.15 pm. During this time she talked to residents, especially members of the residents' committee; to all four senior members of staff individually, often accompanying them in their various tasks; to a group of

domestic staff in the staff room; to several of the night staff; to the clerk; and to other staff informally as situations arose.

At first the researcher felt uncomfortable and self conscious in the role of observer. Working alongside the staff on occasion helped this considerably: on the first visit, for example, helping the staff distribute cups of tea during a skittles match enabled personal contact to be made with both the residents and the staff on duty. Very quickly however the researcher began to feel more familiar with the home and its culture and accepted by the staff and residents. Residents would begin to talk when the researcher came through the door, about the weather or the frequency of visits. Staff too, on occasion, would ask to discuss issues with her. The researcher also began to feel confident in initiating more in-depth conversations with residents and in the process learned a great deal of social and personal history, as well as views of life in the home.

At the end of the visits of observation the researcher was left with a jumble of impressions, memories, notes, thoughts and feelings about the home and its people. Initial relationships had been made and judgements had started to form about people and practices. There were certainly areas which, in the researcher's view, needed changing, on the other hand there was a great deal of good caring work being done.

The home was purpose built some twenty years ago. It is a fairly traditional two storey structure with the public areas at the front of the home and with long corridors of bedrooms and bathrooms leading from it. Eight of the bedrooms are double although the remainder are single. At the rear there is an attractive and beautifully kept garden which is a great asset, although access to it could be easier. The wide entrance hall has seats in it, in addition to lounge seating. Residents could thus sit in this area if they wished and observe the comings and goings. It seemed that people were not territorial about seats in the hall, probably because they already had 'their' chairs in the lounges. This often seemed to be the most lively area of the home.

One of the most striking impressions that remains, was the change of atmosphere in the home according to the time of day. Early morning practices were, at that time, rather rushed and the atmosphere at 7 am was bustling, hurried and rather tense. This corresponds with the findings of a DHSS study (1979) which describes this time of day as follows: "The usual picture was one of frenzied activity by staff who felt under pressure to get through their timetable before their shift ended." Conversely in the evening everything seemed more relaxed: there was more time for people and the general climate seemed more homely and less institutional.

At the time of the visits of observation the day began very early. Residents were woken by the night staff at 6.30 am, when

they dressed, or were helped to dress, and made their way to the lounges where tea was served at about 7 am by residents who had collected the tea trolleys from the kitchen. Occasionally people missed their early morning tea, it was said, if they took much more than thirty minutes to wash, dress and walk to the lounges, thereby having to wait until breakfast at 8.30 for their first drink of the day. Theoretically they could have made a cup of tea for themselves, although in the view of the researcher this facility was never really satisfactory, being situated in a little-used room and not being laid out in a manner conducive to easy and spontaneous use. Also the people who took a long time to dress were likely to be frail and thus unable to make tea easily themselves anyway.

The night staff went off duty at 8 am, having been up all night. In addition a care officer slept in and came on duty at 7 am, although at this time sleeping in officers were getting up slightly earlier to administer medication to a man who was terminally ill with cancer. At 8 am the day staff came on duty. By then everyone was up (with the exception of one man who regularly emerged from his room at 8.30 am precisely) and at 8.15 people started to come into breakfast, which was served at 8.30.

After breakfast the residents went to their lounges or the hall. Coffee was served to them at 10 am and lunch, in the dining room was at 12 noon. Everyone was out of the dining room by 12.40.

Afternoon tea was served at 2 pm. This had been taken around to people in the past, but the officer in charge, in an attempt to encourage participation in afternoon activities, had recently changed this to serving it downstairs where the activities were to take place. In the event some people, especially those upstairs, decided to forego their tea rather than make the sometimes painful and slow journey downstairs again.

The second main meal of the day was served in the dining room at 4.30, and the final meal, a light supper of a hot drink with sandwiches and biscuits, was at 7.30. However only just over a half of the residents came down to supper, the remainder having already begun to go to bed. By 8.30 on the evening the researcher visited the home there were only four people still up in each of the two main lounges where the televisions were. This did not appear unusual and perhaps is not surprising given the early start to the day. It seemed a shame though, especially as 'This is Your Life' was on the television, showing old films of the actor subject going back to the 1930's, which were of obvious interest to the few residents still up.

The day thus appeared to be governed by fairly set routines based largely around mealtimes. Within these there was apparently little opportunity for the residents to exercise choice, and the little there was had sometimes itself been routinised. For example there was a choice of brown or white bread at breakfast

time, but having stated a preference a resident would come to his or her table every morning to find the required number of slices of the requested colour already there, thus denying any daily choice or variety. Another feature was the relatively small number of residents who participated in preparing or serving food. The few who did, for example the men who collected the tea troleys in the mornings, or the two ladies who buttered the bread, did specific tasks daily and one suspected that no one else would have been permitted to help, even if they had wanted to. Certainly the impression was that many more people than actually did participate had the ability to do so. However it was unclear whether this was because of a lack of desire to be more active or lack of encouragement and opportunity to do so.

Supper was the most relaxed meal of the day. As so few people came down to this meal, people could choose their own table companions. There was noticeably much more resident/resident communication, with people talking to residents on their own table and also calling across the room to others. Many more people returned cups to the hatch than at other mealtimes and two ladies washed up. Sadly this meal seemed rushed: a shame in the light of the level of spontaneous conversation. The meal was over in eighteen minutes.

The bedrooms and the lounges were reasonably attractively decorated, although the bedrooms were, in the main, not personalised to

any high degree. Lack of space and built-in furniture precluded large items of residents' furniture, but more shelves, pictures and rugs could have been accommodated. Some residents had brought in many small items and several of them had personal televisions and radios in their rooms, but some rooms were very bare and functional. Again this may have been a matter of choice, although one sad story was of a lady who destroyed her lifetime's collection of photographs because she was coming into the home and so assumed she would have no further use for them.

Impressions of the staff group at the end of the period of observation were mixed. The officer in charge had only been in the post for about a year; she had already initiated some changes and wanted to introduce others. The deputy and her husband had been in the home far longer and had experienced several changes in routine as senior officers came and went. They did not see all change as positive, recognising strengths in previous heads, but they were not against change in principle. The third officer, an ex field worker, was entirely in favour of change towards more resident-oriented practices, although she was doubtful whether such change could be achieved in the home. The other care staff had varying views too. Some liked the way things were at that time and thought that fixed routines were the only way to enable the work load to be accomplished, given present staffing levels; others welcomed the prospect of providing more individualised care. The domestics and the night staff were,

interestingly, the two groups of staff who most frequently spontaneously talked to the researcher about the quality of care being provided. The domestics, for example, spoke of the need to 'revere' elderly people and the importance of time to listen. One had been widowed herself and said this made it easier for her to undertand the loss residents had often suffered. Similarly two members of the night staff talked about the importance of dignity in relation to elderly people, and how they would like to feel happy for their own parents to live in the home. Both of these groups of staff were quite critical of some of the routines in the home, seeing them, often with some insight, from the residents' point of view. The domestics, for example realised that some residents missed tea at 2 pm because the journey downstairs was too much for them. Some would have liked to have permission to take tea to these people, but they felt this would have met with disapproval. Significantly, it seemed, they did not raise this with the senior staff, and indeed felt they were being discouraged from contact with the residents which they all valued highly.

The researcher saw no evidence of this from the attitude of the officer in charge, but there is no doubt that the domestics perceived the situation in this way. What seemed such a shame was that these issues and feelings were not aired or resolved. Once again the researcher was tempted to get involved directly, but the legitimacy of doing so, if people were not able, for

whatever reason, to bring things up with the staff involved, seemed dubious, particularly as the role of the researcher was at that time that of observer. All she could hope for was that such issues of communication between staff could be raised in the group sessions, and could be dealt with there. Some members of the night staff were critical of early morning practices, seeing it as inhumane, even cruel, to have to get people up so early if they did not want to do so. They said they would like to give residents tea in the morning and to wake them more gently, but that pressure of work, to get everyone up by 8 am, precluded this. They reported that only people who were sick were allowed tea in bed and that as soon as they began to feel better they had to get up early again, even if they did not feel like it. (This was confirmed by a resident as being the practice in the home. However she approved of it happening, saying that discipline was essential. "Can't is spelt T.R.Y." she said vigorously). It was interesting to note that these staff reported far more things they 'had' to do or were not allowed to do than was apparent when talking to or observing the officer in charge. Such differences in perception were very real to the parties concerned, whatever the 'truth' of the matter. Significantly perhaps, it was again these two groups of staff, the domestics and the night staff, who reported perceived tensions between themsleves and the care staff. It is interesting that in each case it could be seen to be the group with the lower status that felt and reported these tensions; the care staff tended not to.

The residents' views of the home varied from one rather pessimistic man's opinion that it was "like a prison camp," to the much more prevalent view that the care was good. The degree of acceptance, by adults, of much of their autonomy and freedom of choice being eroded, however good the care, was striking, although hardly surprising in the light of the literature on life in institutions. Many residents expressed especial feelings in relation to certain care staff, often their key workers; and two residents, without being asked, spoke about particular practices which they valued highly. One was in relation to bathing, when the key worker, knowing the resident liked a soak, let her have "a nice long bath every week." The other was in regard to tidying drawers: when the key worker thought it was time to do this, she would suggest it to the resident and ask if she would like to help her or be present whilst it was being done. Discrete enquiries established that these two incidents referred to the same key worker who appeared to the researcher to be very perceptive and showed great warmth towards the residents, kissing one old lady goodnight quite spontaneously to their obvious mutual delight.

One resident, on being asked if she had many friends in the home, replied that she spoke to the people she sat next to, although they did not have much in common. She added that there were a few people in the home that she had thought over the years looked interesting and whom she would quite like to know better. When the researcher asked why she had not pursued these promising acquaintances, she replied with some asperity, "It is

propinquity not liking that determines contact." This wonderful remark, that almost had the researcher searching for a dictionary, illustrated so clearly the impact physical environment can have on social relationships, and how much elderly people are at the mercy of such environments unless somehow their voices can be heard.

Trying to sum up such diverse experiences with so many different people in one institution is difficult. It also has to be said that the period of observation was, in fact, quite short: less than fourteen hours over a period of two weeks. Also what was observed may not have been representative of what normally happened. In addition account must be taken of the impact the reseracher's presence had on people's behaviour, and that the personal values of the researcher and her purpose in the home undoubtedly predisposed her to perceive things in certain ways. Nevertheless people seemed to act naturally during this period and the value base of the research project had at least been made explicit to the staff at the full staff meeting.

It appeared, then, that the home was characterised by many quite well-established routines, based largely around meal times and other daily activities, some of which were significantly different from life outside the institution. Rising at 6.30 could be seen in this category, although one has to remember that some, but not all, of the residents may have risen early all their lives.

Jones and Tutt (1983) writing about the normalisation principle in relation to people with intellectual impairments, say this entails making available to all people the patterns of life and conditions of every day living which are as close as possible to the ways of life of their society. It seemed that although effort had already been made to move in this direction within the home, more could still be done. Perhaps illustrative of the way in which life in the home was different from outside was the importance accorded to the issue of tea within the establishment. In their own homes people have tea when they want it and in the main think nothing of it. In the home, because it was routinised, tea became a major issue for all sorts of people and came to symbolise such 'big' issues as freedom of choice and autonomy, or the lack of these.

Having said that the home was traditional with many set routines, one must add that there was considerable awareness and acknowledgement by staff at various levels in the hierarchy that change was desirable. Some change, such as the introduction of a limited key worker system, and the setting up of a residents' committee had already been effected; and the very fact that the research proposal had been accepted suggested a desire to continue that change process, towards more individualised care and resident participation. It must also be said that the existence of routinised practices, which inevitably militated against resident oriented care, did not preclude good caring practice occurring. An account

of the warm, intuitive work of one key worker has already been described above. Another excellent piece of practice that immediately springs to mind is the highly efficient but also very understanding and empathic way in which two members of the care staff dealt with a distressed resident who had soiled herself in a public lounge. Many other such incidents could be recorded as well, and thus in this sense describing the home as traditional with many fairly inflexible routines, is not a personal criticism of the staff involved, but rather evidence of the ways in which large institutions appear to have inherent structural problems which predispose them towards institutionalising practices (see Chapter 2 on total institutions and institutionalisation for a further development of these ideas by, amongst others, Goffman, 1961 and Smith,1979).

In conclusion the following is a quotation from the notes made by the researcher immediately after the period of observation was completed, which summarises the impressions gained, "A fairly traditional home with many routines firmly established, but with some good caring practice and some considerable acknowledgement that more change needs to be effected."

3.6 EVALUATION OF THE INSTITUTIONAL ENVIRONMENT

A subjective but fairly detailed evaluation of the institutional environment, based on meetings with the staff and a period of observation in the home (see previous section) had already been completed. However, in order to monitor the effects of

the work to be undertaken with the staff group, a more systematic analysis of the current residential environment was thought to be required at this stage, which could in some way be quantified and compared with a later score, when the instrument was administered again after the work was completed.

A previous section on some of the theoretical considerations relating to evaluating institutional environments (Chapter 2.4) outlines the instruments available and the reasons for the choice of the Analysis of Daily Practices schedule devised by Evans et al. (1981). In their comparative study of six elderly persons' homes in Manchester, Evans et al. arranged for the schedule to be completed independently by two main workers who had been involved in each home for four to six weeks, observing and interviewing residents and staff. At the end of that time they completed the schedule on the basis of all the data collected. The two scores were then compared and where disagreement occurred a consensus score was negotiated 'by discussion and consultation.' Evans et al. (op cit) reported that inter-rater agremeent was high and few changes in the scores had to be made.

A decision was made to emulate the experience of Evans and his colleagues and to ask the social services officer to administer the instrument in addition to the researcher, as a control. The former already knew the home well, and in addition gathered data by asking the questions of at least four care staff at different levels of seniority within the home. The researcher

based her answers on visits of observation, covering most of the waking day, and on interviews with staff and residents over a period of several weeks. Thus it was hoped to achieve a fairly accurate measure of the institutional environment, both before and three monghts after the work with the staff group was undertaken in order to evaluate its effectiveness.

The schedule was designed to assess 'the extent to which a home had adopted resident-oriented or institutionally oriented practices.' Evans et al. go on to say that, "institutionally oriented practices were defined as those which tended to limit rather than enhance resident freedom, choice or privacy; to facilitate administrative efficiency at the expense of meeting the needs of the residents; to regiment the resident or subject them to 'block' or 'conveyor belt' treatment; to depersonalise residents by eroding individual difference or limiting opportunities for making decisions; and to maintain social distance between residents and staff."

There are four sections to the schedule: resident care, resident autonomy, staff/resident interaction and organisational practices and features. Each section contains a number of questions, the answers to which are coded 0 or 1. A low final score denotes a home with resident oriented practices, a high score a more institution oriented regime. In the Evans survey, of six residential homes for elderly people in the Manchester area, the total scores ranged from 32 to 66.

The researcher based her answers to the questions on her observations in the home and on her discussions with staff and residents. Where there was a conflict between what was said to be the practice and what was observed to actually happen, the observation was recorded. For example in the question relating to visiting times in section 4 (organisational practices and features) the officer in charge reported that there were no restrictions. However on the front door was an old notice which asked visitors not to come at meal times or after 8 pm. The decision was made therefore to record that visiting was restricted. Similarly, in section 3 (resident/staff interactions) staff said that they did not infantilise residents, yet a couple of members of staff when talking to the residents did, in the researcher's view, infantilise them and one even referred to them as being like children. Thus the score was based on practice, not on what people said they did, as far as possible. Occasionally different staff or staff and residents perceived practices differently. When this occurred the researcher would try to ascertain what happened in reality, either by observation or by asking other people for confirmation or otherwise. For example, the officer in charge when asked whether residents were consulted before outings/functions were decided upon (section 4: h3) answered yes. A resident however reported that decisions were made by staff about where to go and then residents were asked if they would like to go to the place chosen, an interesting shift of emphasis, which was confirmed by the officer in charge and led

the researcher to record that residents were not consulted before outings were decided upon.

The social services officer based her answers on her knowledge of the home and the answers to the questions given by at least four members of the care staff at various levels in the hierarchy of the home. If the answers were unanimous, or at least three answered the same way, she recorded the answer accordingly. If two people responded one way and two the other, she tried to resolve the dilemma by asking more people or by observation. If opinion was still divided, she scored 0/1? and consulted the researcher later.

It became apparent as soon as the two raters began to fill in the schedule that there was significant room for interpretation and judgement in some of the questions. For example in the first section there is a question that asks whether able residents choose when to get up. The answer to that question is yes they do have choice, provided they want to get up before 6.30 am. This seemed a big proviso, so the answer was recorded as no. Another example from section I: b3 asks if males and females are toileted in separate facilities. In the home this was the case downstairs but not upstairs where facilities were shared. Yet another question asked if certain practices were 'extensive' without providing a definition of that word.

A different sort of difficulty arose over the second question in section 2 (resident autonomy) regarding the choice of new clothes allowed to residents by the local authority. No one knew of the existence of such an allowance and so finally the question was deleted, reducing the maximum score to 77.

Possibly because of the room for judgement and interpretation in the answers, the original scores awarded by the two raters proved to be quite different: the researcher scoring the home 38 and the social services officer 24, a much bigger discrepancy than Evans and his colleagues implied. The original scores for each of the sub-sections are given below, in Table 3.1, together with the final agreed score.

Table 3.1 Table showing the original and final agreed scores on the Evans schedule

	Researcher	Social services officer	Agreed score
1. Resident care (maximum 21)	15	10	13
2. Resident autonomy (maximum 20)	8	6	7
3. Staff/resident interaction (maximum 9)	3	0	3
4. Organisational practices (maximum 27)	12	8	11
Totals (maximum 77)	38	24	34

The size of the difference in the scores was, at first, alarming. The social services officer had scored the home as significantly less institution-oriented than the researcher. A cynical analysis of the two scores in the light of the respective roles of the raters vis a vis the home might have suggested that the social services officer, in her adviser's role, wanted to see the home in a positive light, whereas the researcher, wanting to change things for the better, tended to see the less edifying aspects of the home. However a closer analysis of the scores revealed far less disagreement than was at first apparent.

The scores about which there was disagreement seemed to fall into two categories: the first, with eight discrepancies of scoring falling within it, seemed to be where the answer was unclear or ambiguous; and the 2nd category, also with eight items, was where the source of the disagreement lay in the difference between practice as reported and practice as observed. Table 3.2 summarises the differences in the scores (see page 120).

A meeting was arranged between the two scorers to try to negotiate an agreed score, which, in the light of the sizeable differences in the individual scores, proved remarkably easy. Taking the unclear or ambiguous answers first, the questions were as follows:-

Section 1:d1. Can residents choose when to go to bed? The answer was that able residents could choose but that disabled residents

were dependent on staff being available to help them, thus they did not have freedom of choice. The score was therefore agreed as 1 (no).

Section 1:d3. Is there extensive use of sedation? In fact seven out of 57 residents were sedated and the question was whether this was extensive or not. Finally the two raters agreed to define extensive as 17 residents, that is approximately one third of the total number. By this definition the use of sedatives was not extensive and the score was agreed as 0.

Table 3.2 Table showing summary of inter-rater discrepancies

Answer unclear/ ambiguous	Talk of practice/ observed practice
1:d1	1:a1
1:d3	1:d2
1:e4	2:f3
2:c2	3:a3
4:c3	3:c1
4:f2	3:c3
4:g1	4:c1
4:h1	4:h3

Section 1:e4. Do staff routinely dress many residents? The problem was what constituted 'many'. Again the decision was made to make 17 the definition and as only about seven were dressed regularly, the score was 0 (no).

Section 2:c2. Can all residents spend their money as they wish?

It transpired that two very confused people had their money controlled by the staff, a very small number, but the question includes the words 'all residents' so the decision was made to score 1 (no).

Section 4:c3. Do staff control their daily work routine? Both raters discovered that what had to be achieved each day was laid down for staff, but that many made their own decisions about how to achieve this or in what order. Finally it was decided to score 1 (no).

Section 4:f2. Are facilities adequate for disabled residents? Everyone agreed that they were in the main adequate, but the officer in charge was critical of the siting of the baths, causing the researcher to score 1. After discussion the two scorers agreed facilities were generally adequate and scored 0 accordingly.

Section 4:g1. Are visiting times unrestricted? Everyone said there were no restrictions, however the researcher had read an old notice on the front door, asking visitors to refrain from visiting at meal times or after 8 pm. It transpired later that everyone, including the officer in charge, had forgotten the existence of this notice. Nonetheless the decision was made to score 1 (no).

Section 4:h1. Are regular outings/functions a feature of the home? (at least once a month). The consensus was that outings exceeded once a month only in summer, and it was then winter. However it was agreed that on average outings took place once a month so the score of 0 was agreed.

The second group of scoring discrepancies related to differences in what was said to happen and what had been observed to happen. The two scorers agreed in every case to score according to observation of actual behaviour, even though there was a danger that it may not have been typical. Most, therefore, were quite straightforward but two are worthy of special mention. Section 2:f3 asks whether residents can choose where to sit in lounges. At first it seemed that the answer was no, in that each seat was clearly 'owned' by someone and a new comer would have little choice about where to sit. However further study revealed that this was a resident initiated practice and thus their choice. The raters finally, after much discussion decided to score 0 (yes). Section 4:c1 asks if there are regular staff meetings. The officer in charge said they were regular, and there is no doubt she intended them to be, however the social services officer, on talking to the care staff, discovered that a series of external events had meant there had not been a meeting for some months. Reluctantly therefore the scorers decided the answer was no (score 1).

Thus relatively easily, given the original discrepancy, the final score was agreed as 34. The complete scoring schedule is included as Appendix 2. In retrospect many of the discrepancies could have been avoided with a little foresight on behalf of the researcher. For example the definition of 'extensive' and 'many' could and should have been agreed beforehand. Once having made these often arbitrary decisions about scoring, the second

administration of the schedule became much easier, in that if there was no change the score remained as before, and in fact discrepancies in scoring the second time round were almost non-existent (see Appendix 2).

Despite reservations about imprecisions in the instrument, and the sometimes arbitrary way in which they had overcome these, by the end of the meeting both raters were happy with the agreed score of 34, feeling that it was a fair reflection of the environment of the home. The use of the schedule was an attempt to evaluate the residential environment quantitatively and relatively objectively. The final score, compared with the six in the sample of Evans et al. (always assuming the interpretations made in order to fill in the schedule were similar) showed the home to be within their range of experience, tending towards the resident oriented end, their lowest score being 32.

Thus by the beginning of November 1983 the residential environment had been evaluated by observation and by the Analysis of Daily Practices schedule. It was time then to begin the action research itself and start to work together with the staff to try to make their work more resident-oriented.

3.7 THE GROUP SESSIONS: the work undertaken with the staff.

3.7.1 Introduction

The fifteen group sessions with the care staff and, on occasion, the night staff, constituted both the climax and the largest part of the fieldwork for this stage of the research.

In summary, the following may be seen as the research proposal which had been negotiated and accepted by the staff of the home. (see Table 3.3 below).

Table 3.3. Table showing summary of action research proposal

Research proposal

Aim:	to improve the quality of the environment in an elderly persons' home.
Objectives:	1. to work with the staff of the home to enable them to identify practices seen as likely to engender institutional dependence. 2. to move towards more resident oriented practices, as outlined in the Analysis of Daily Practices Schedule (Evans et al. 1981).
Method:	a series of fifteen weekly meetings lasting one hour.
Location:	the small downstairs lounge.
Membership:	all care staff on duty, and night staff and others when invited (when the practice area being discussed concerns them.)
Group leader:	the researcher.
Recording:	each session to be recorded by the researcher and the record to be posted up in the staff room for all staff to see.

The researcher drew upon the literature of action research, group work and the social sciences generally to inform this part of the fieldwork.

Kemmis (1981) maintains that the term action research was first used by social psychologist Kurt Lewin in 1944. It was seen as a means by which both the advancement of social science theory and social change might be achieved simultaneously. Kemmis quotes Lewin (1946) as saying that action research "consisted in analysis, fact finding, conceptualisation, planning, execution, more fact finding, evaluation; and then the repetition of this whole cycle of activities." Lees (1975) argues that action research is characterised by a fluid relationship between researcher, fieldworker and administrator, trying together to improve the effectiveness of the service. Like Lewin, Lees suggests spiral stages in the process of action research (1975, page 78):

1. evaluation of a particular situation;
2. decision about what needs to be or can be improved;
3. strategy to bring about improvement;
4. evaluation of effectiveness of action;
5. re-assessment of the situation with a view to additional and modified action strategies if required.

In similar vein Kemmis (1981, page 84) describes action research as involving "the identification of strategies of planned action which are implemented and then systematically submitted to observation, reflection and change. Participants in the action

being considered are integrally involved in all of these activities."

Writers on action research stress the importance of the participation of the practitioners, both because it enhances the possibility of effective change, but also because it is ideologically a democratic approach, seeking to involve practitioners in the formulation of theory as well as in practice. It constitutes, therefore, a criticism of traditional research for seeking to initiate change through the publication of research results alone, and suggests instead the involvement of practitioners in the research process. Kemmis (1981, page 84) for example, writes, "The aim of involvement stands shoulder to shoulder with the aim of improvement," and again, "action research is a democratic form of research."

Both Kemmis (1981) and Lees (1975) argue that action research is better if initiated by the participants rather than the researcher. However Kemmis goes on to say that in the field of education in Australia most action research projects are still initiated by the researcher or facilitator. This project too was initiated by the researcher, although care was taken to ensure that the participants shared the researcher's perception of the problem and agreed in general terms with the direction in which she wished to move. Certainly the officer in charge, when first approached about the possibility of the research, wanted to change in the direction being suggested.

The broad concept of the group sessions can thus be seen as an example of action research with the staff of an elderly persons' home. However previous sections have also shown the importance of group work theory in guiding the preparation of the setting up of the group. This remained important and helpful in guiding the sessions themselves, particularly in such areas as leadership, group stages and group cohesion.

As well as drawing on knowledge areas, the researcher required certain skills to undertake this part of the research. It is possible to list some of these, such as enabling, listening, motivating, encouraging, summarising and so on but the list could be almost endless. In reality the researcher was most aware of reaching deeply into helping skills largely learnt in the context of Rogerian counselling: what Truax and Carkhuff (1967) call the "core facilitative conditions" of genuineness, acceptance and empathy, which they describe as necessary but not sufficient for effective helping. Carole Sutton (1979) in an attempt to arrive at an eclectic approach to helping, suggests that what is needed in addition to these core facilitative conditions is some form of decision making and goal planning. This certainly proved the case with the group sessions, and evaluation needed to be added as well. In addition to helping skills the researcher inevitably drew on her teaching experience. Perhaps the hardest skill of all was in deciding when to listen and when to give information or ideas or to suggest exercises

in order to facilitate change. Time and time again the importance of starting where people are was reinforced and the desire to move more quickly or to push particular ideas had to be, sometimes painfully, resisted. As in all groups the "sensitive balance between focus on persons and focus on task" had to be maintained (Brown 1979).

It is proposed to write up the group sessions under the main headings of process and content before going on to evaluate them. Summaries of the proposed programme, the actual programme and the issues raised during each session are included as Appendix 3. In general the actual programme corresponded quite closely with what was planned before the sessions began. Occasionally, however, the researcher wanted to go faster than the group was able to move. An example of this was the examination of early morning practices. The researcher, rather naively, given the complexity of the task and the stage of the group, expected this area of practice to be evaluated and decisions made about change in a couple of weeks. In the event it took at least five sessions. On another occasion one member of the group needed to talk about her own personal situation so much that to concentrate at that time on the task would have been both insensitive to the individual concerned and counterproductive in terms of the group and its task. In the main, however, the material both from the researcher and the group appeared to be relevant and the pace was dictated largely by the group itself.

3.7.2 The group process

Brown (1979, page 65) defines group process as, "those changes occurring in the activities and interactions of group members that are related to changes in goal attainment and group maintenance."

One of the main processes of any group is the stages of development it passes through. Tuckman (1965) identified four stages through which groups progress, to which Brown adds a fifth. These are forming, storming, norming, performing and mourning.

The first stage, **forming**, is characterised by a series of individuals concerned with issues of joining the group. They will tend to employ strategies which have been useful to them in the past as models for the role of group member. Members will tend to look to the leader for guidance most at this stage and many will feel threatened and anxious about their role. If some members already know each other outside of the group, they will bring their past history into it. Brown maintains that the task of the leader during this stage is to help members join into a group by using exercises or group tasks. The leader at this stage also has to establish his or her own credibility with the group members.

Not surprisingly, this stage was most obvious in the first few sessions when people were unsure of their roles and what would happen in the group. Especially in the first session there was

a great deal of reliance on the researcher to provide direction. In order to establish quickly the participative nature of action research and the democratic approach it was hoped to adopt, the researcher suggested some time be spent during the first meeting of the group establishing groundrules for the group and deciding on a list of values which should guide practice. Using these methods everyone was encouraged to speak and the principle of participation in decision-making was established early on. Nevertheless there was considerable pressure to be directive, which was especially difficult to resist towards the end of the session when time was running out. Since few, if any, of the members had any previous experience of being a member of such a group, many of the groundrules had to be explored in some detail and often returned to later. However the time spent thinking through the implications of these groundrules proved useful as a reference point later on.

During the third session, the night staff attended the group and later on members of staff who had been sick attended for the first time. On each of these occasions at least some of the time seemed to be spent 're-forming' the group: returning to this stage even if later stages of group development had been achieved.

Since everyone, including the researcher to some extent, knew one another before the first group session, what Brown (1979)

terms 'past history' was inevitably brought into the group. Previous knowledge of co-members clearly obviates the necessity to get to know one another, but has the disadvantage of bringing previously existing sub-groups into the newly formed group. This did appear to happen to some extent in that people clearly came to the group with views about other people's attitudes to change. On the other hand it appeared that the group quickly evolved its own culture, different from that of staff meetings, and to some extent this enabled people who were resistant to change to express their views in a usually acceptant and understanding climate which sometimes enabled them to move forward. At all times the group tried to listen to and understand what other people were saying, although it was clearly difficult for some at various times. For the researcher the most difficulty in this respect centred around different meanings of the word 'independence'. To the group members it gradually became apparent it meant maintaining physical mobility for as long as possible using what became an in-group term 'gentle force'. To the researcher it meant maximising self determination. It was sometimes difficult to be acceptant and understanding of such a different viewpoint.

The second stage of **storming** is critical in determining a group's effectiveness. It is characterised by conflict as members jockey for position and find roles in the group. Brown maintains the issues of control and power are uppermost at this stage, as

members realise no easy solutions are going to be provided. Shared tasks can be useful in helping people see the way forward both in terms of arriving at solutions and showing the way to achieve them. This stage was most apparent to the researcher in sessions 2 and 4, when one or two members seemed to challenge the whole purpose of the group and the researcher by continually emphasising constraints and the impossibility of change. This was overcome by attempting to accept the fear of change and the validity of many constraints at the same time as encouraging other people to find creative and imaginative ways around the difficulties. Thankfully, by session four the latter predominated and seemed to be accepted by the majority as a model for the group's functioning.

Norming is the third stage of group development. A group at this stage begins to develop trust and cohesion: it begins to develop its own culture and become important to group members. This is shown by members being prepared to be themselves more. The task of the leader is to 'harness this group togetherness and cohesion for task achievement.' (Brown 1979, page 70). This stage appeared to start in session three, when members visibly relaxed, despite the addition of the night staff to the group, used humour more and were able to cope with more self disclosure. Later, however, in sessions four and five, backward steps were noticeable and it was probably only by session six or seven that this stage was reached in a sustained way. Session three

was probably so successful because the researcher, realising the previous week that she was expecting change too soon, really tried to start where people were with a series of participatory exercises which were about the group members themselves and not the residents. This freed a lot of people and enabled them to move.

Performing is the next stage and different from the previous stage only in emphasis. Brown (1979, page 70) says, "The point at which group members begin to take responsibility, individually and corporately, for the group and its tasks, is the point when they are ready to perform." This stage, where the group members use their own skills and potentials to help achieve the group task, is an exciting one. It became apparent that the group felt enough trust and support to begin to function at this level in session eight, when members themselves challenged one member of the group in a supportive way: confronting her with what she was doing but in such an enabling way, and using humour, that she was able to acknowledge her own weaknesses. It was during this session too that people began in a significant way to talk about themselves. The content of the session, how to talk to people about possibly painful feelings, may have helped in this respect but the stage the group was at was important too. Everyone appeared moved by this session and people began to challenge both the researcher and other members in constructive ways and to contribute more of themselves. The following week

one member wrote in the Changing Practices book, one of the first times it was used. This book, kept in the office, was a book intended for people to note down any examples of their own or others' changing practices. The incident recorded described how a member of the group, following the previous session's discussion about the importance of listening, had stopped and listened to an old lady talking about how it would have been her golden wedding anniversary that day, had her husband lived.Later the resident called the member of staff back to thank her for listening. It was a lovely example and the feedback for the member of staff concerned was worth a great deal. At this time in the group members seemed to show considerable mutual respect and to adopt a constructive approach to problems generally. However in the following session, the tenth, a member of staff new to the group arrived. She was very outspoken, even provocative, and clearly not used to or accepting of the culture that had evolved in the group. This new group member articulated the group's feeling about the meaning of 'independence' referred to earlier and forced into the open the realisation that the researcher and the group members had very different perceptions of the meaning of the word. The term 'gentle force' was coined at this meeting and it became a powerful term summarising succintly the attitudes of the staff. This affected the group considerably and the issues of authority and control of the storming stage were raised again. To some extent the setback was temporary and certainly the new member quickly became a

valuable member of the group. However, during this tenth session the researcher also failed to pick up until the end the very strong feelings around in the group about the new early morning procedures which had just been implemented. Small misunderstandings and miscommunications had led to some very strong feelings and these needed to be aired. The incident also illustrated the care needed and the difficulty in effecting change and so perhaps questioned once again the wisdom of the group's avowed function. It seemed somehow to support the minority view of the impossibility of change without upsetting everyone and creating chaos. However the following week these issues were addressed with the night staff and most difficulties were resolved with the consensus view being that the changes were very much for the better. The 'independence' issue, on the other hand, remained and the theme of staff control on the one hand or the residents' right to choose on the other came up time and time again, but was never, in the researcher's view, successfully resolved. Nonetheless in later sessions the cohesion of the performing stage became apparent again, showing itself in the members' easy ability, compared with the early stages, to put themselves in the shoes of the residents and thus to look critically and constructively at their own practice.

The final ending, or mourning stage of a group is often characterised by wanting the group to continue beyond its agreed life. Evaluation of the usefulness of the group is said to be inevitable,

together with some sadness, if the group has been successful, at the loss of important relationships. At this stage the group needs help in going back to the real world: in this case the home without the existence of the research group. The group illustrated these characteristics very clearly. Many members felt that they had begun to achieve something valuable and they wished it to continue. There was no possibility, however of this being the case and this had been made clear from the start. Nonetheless what the group did do was decide to meet fortnightly as a care staff group without the researcher but using the research group as a model, to continue to look at their own practice. It was heartening at this stage to hear one member of the group, who was quite resistant to change, express surprise that the weekly research group had not led to chaos in the home and that it was possible to make time to look at practice issues. Certainly there was sadness on the part of the researcher, that the group had come to an end, and this feeling appeared to be shared by the group members. On the other hand it did seem that the proposal to continue the group in a different form was a realistic way of carrying on the work already begun.

Apart from group stages, another aspect of the process of a group relates to the various roles which are adopted by group members. Brown (1979) describes how members who are unable to resolve difficulties in the storming stage may resort to encouraging someone to adopt the scapegoat role onto whom all

the difficulties of the group can be projected. Alternatively, or in addition,a joker may emerge who can use humour to evade confronting painful issues in the group. Whilst there were occasions when humour was used in this way in the research group, this did not appear to be the province of one person in particular, possibly because the group did evolve normative ways of enabling members to look at difficult issues. Neither did anyone very clearly emerge as a scapegoat. However it is possible that on occasion attempts were made to scapegoat the researcher by blaming her for upset caused by change. These attempts, however, were minimised by the participative nature of the research and were in any case not very strong or sustained. One member, usually fairly resistant to change, said on one occasion that she felt she was being 'got at' by others in the group. Whether this did constitute scapegoating or legitimate confrontation is difficult to judge. However the member concerned was encouraged to continue to express doubts and perceived constraints and did on occasion suggest positive ideas as well.

Other roles were adopted by various members of the group at different times; several for example could be seen as enablers or facilitators, and occasionally the initiating role would be taken on by a group member. Apart from this however the leadership role usually remained with the researcher. This was not the intention, but is perhaps understandable given the relative inexperience in groups of most members. The officer-in-charge,

as has already been described, chose not to adopt a formal co-leader role, yet neither was she, by virtue of her seniority, just an ordinary member of the group. Her usually quiet support for the initiation of change was almost always apparent and in many ways she formed a bridge between theory and practice, since she was professionally qualified and was thus more familiar with theoretical ideas, at the same time being immersed in the home and its day to day practice issues. In terms of bringing about change she was perhaps most helpful in giving people permission to change, as their line manager. For example one member described graphically her feelings of guilt if she sat and 'just talked' to residents. The officer-i-charge was able, with the authority of her position, to legitimate 'just talking' and thus give permission and actual encouragement for it to occur. The way in which she was able to delegate to the group the power to make policy decisions about the day to day running of the home has already been commented upon, and although a right of veto was obviously retained, the fact that it was never used says much for the democratic style of her leadership in the home. It also demonstrates how people act responsibly when involved in decision making and power sharing.

Kemmis (1981) prefers the term facilitator to that of leader. He quotes from the observer's report of an Australian National Seminar on action research in 1981 as saying, (page 90) "The term facilitator is employed because it encapsulates the stance

of an outsider supporting the primary actors in the sometimes hazardous task of self reflection ...This must be done in such a way that participants retain intellectual ownership of and responsibility for the problems addressed, and of the strategic action taken. Only under these conditions can the understandings achieved be authentic and the risky decisions of practice justified by those responsible for them."

Accordingly, Kemmis describes the facilitator's role as a) providing access to appropriate theory, b) ensuring symmetrical communication, by which he means helping the participants take responsibility for what happens rather than it being left to the direction of the facilitator; c) practically assisting in the organisation for action and reflection; and d) assisting in the process of reflection. It is important to note that the facilitator is not usually present at the moment of action: the new way of doing things. His or her role is to enable participants to decide on change and how to implement it and then provide opportunities to evaluate the change and modify it if necessary.

The researcher was aware of these aspects of her role throughout the life of the research group and at various times performed each of them. Reflection suggests that the main limitation was in ensuring symmetrical communication. It is easy to find 'reasons' why this was the case. The relative inexperience of the group members has already been commented upon, as has their general

lack of professional training. In addition the home, like many others, is hierarchical and the researcher, an ex-tutor of the officer-in-charge, was inevitably seen in this context also. People needed time to develop confidence to take the initiative and certainly towards the end of the group sessions they were doing so significantly more than at the beginning. Nonetheless one also has to accept the possibility that the researcher was unable to give up her leadership role in the group and needed to be directive at times. Certainly the temptation to be directive was occasionally extremely strong, for example on the 'independence' issue, but equally the temptation was strongly resisted. In reality it was probably partly the inexperience of the group members and partly the stubbornness of the researcher which together prevented true symmetry of communication occurring: democracy is hard to achieve. Nevertheless the leadership style was probably relatively non-directive, facilitative and acceptant, and at least an attempt was made to balance the task and the socio-emotional needs within the group and to share these leadership tasks with other members where possible.

One further aspect of the group process which must be described is the recording process. Douglas (1976, page 114) refers to recording as 'group memory'. The researcher recorded the content of each of the weekly group sessions and posted the papers up in the staff room for all staff to see. Also, for the purposes of writing up the project, she recorded any process issues or

ideas or comments about methods. Group members appeared interested in the records and occasionally commented upon them. The researcher is unaware how much they were read by staff who were not group members, but odd comments suggested that some at least glanced at them and more were aware of their presence and valued it insofar as it symbolised the desire to involve people in what was going on.

3.7.3 The content of the group sessions

Rather than describe the content of each session, it is proposed to present the material under six headings corresponding to the substantive areas which were explored by the group during its lifetime. These are:-

a) The negotiation of groundrules: session 1.

b) The negotiation of an agreed purpose of residential care and the values which should guide practice: session 1.

c) Early morning procedures and practices: sessions 2-5, the end of session 10 and session 11.

d) The development of the role of key worker within the home: sessions 6-10 and 12-14.

e) The role of activities within the home: session 15.

f) Evaluation of the group by participants: session 15.

A summary of the content of each session is included as Appendix 3; and Appendix 4 lists the main exercises undertaken by group members during the fifteen sessions.

a) The negotiation of groundrules

The negotiation of groundrules to guide the group was one of the first tasks undertaken by the members. In making the groundrules open to negotiation the researcher hoped to illustrate that responsibility for what happened in the group was shared, and that with that responsibility went the power to determine the guidelines and the subject matter of the group. It was, in other words, an early attempt to put into practice the commitment to democratic and participative forms of working. Since no-one in the group had ever participated in such an exercise before, it was sometimes necessary for the researcher to suggest issues to be debated. Once the issues were out in the open, however, the group members were able to discuss them and make decisions about them. Apart from enabling group members to look systematically at the way the sessions would operate, this exercise also afforded the group the opportunity to explore expectations of various people's roles within it.

The groundrules eventually decided upon where as follows:-

1. Membership: to be as stable as possible to provide consistency and to help the group achieve its goals.
2. Recording: the researcher to record the content of each session and post it in the staff room for all to see. Members to have the right to challenge what was written if it did not accurately reflect what happened. The researcher also undertook not to use

names of people in the writing up of the project.

3. Openness and honesty: all participants in the group to be as honest and open as possible, recognising that differences of opinion are inevitable and that these should be acknowledged and dealt with as far as possible.
4. Consulting other staff: other staff to be consulted as much as possible during the research period to keep them informed. In practice this meant:- posting the group records in the staff room; inviting other groups of staff to the group sessions if the areas of practice being discussed involved them; and giving reports of the progress of the group to full staff meetings.
5. Changing Practices Book: this book to be kept in the office and group members to write any positive changes of practice they were aware of in themselves or others. The contents of this book and any individual notes made to be shared at the beginning of each session.
6. Additional groundrules: to be added later if need be, by negotiation with the group.

These groundrules were written up on a large sheet of paper and displayed on every occasion the group met. Various members referred back to them at different stages in the group's life, and they proved a useful reference point.

b) The negotiation of an agreed purpose of residential care and the values which should guide practice

Lees (1975) writes that prior agreement about goals is probably

necessary for successful action research and that values should be made explicit. The participants in the group had agreed to work with the researcher to move towards a "more resident oriented practices." However it seemed necessary to be more explicit about the value base underlying people's practice and to arrive at an agreed definition of both the purpose of residential care (or its goals) and the shared values which should guide practice.

Group members, on being asked what their view of the purpose of residential care was, were clearly unsure about how to even begin to answer. The researcher, suspecting in advance that this might well be the case, presented a suggestion made by Walton and Elliott (1980) that, "The purpose of residential care is to provide settings in which people's needs (emotional, physical, social, intellectual and spiritual) are most likely to be met." This quotation provoked a great deal of discussion and immediately began to raise issues of individuality and the importance of meeting needs beyond the physical. The consensus view was that this was a helpful definition of purpose and one to which people generally subscribed.

The next task was to devise a list of values that group members felt should guide practice. This proved easier for people since they had already, in previous contexts, mentioned spontaneously the importance of dignity, for example, in relation to the care

of elderly people. The following list was compiled, amidst much discussion and debate:-

dignity

understanding/patience

respect for residents and colleagues

availability of choice

opportunities for privacy

time to listen

recognition of individuality

communication

encouragement towards independence (but not officiously)

opportunities for stimulation (but not enforced)

opportunities to participate

autonomy, i.e. control over own life as far as possible

as normal a lifestyle as possible.

By this time almost everyone had contributed and it was obvious that people were thinking hard. There was some disagreement about some of the ideas, but they were not recorded on the sheet of paper until agreement had been reached. The group requested that the list be pinned up in the care staff's office where people could be reminded of the values. This seemed to indicate a fair amount of ownership of the ideas expressed and the poster was duly put up, being taken down each week to be displayed in the room where the group met. This sheet of paper showing the purpose of residential care and the values agreed proved to be one of the most useful and important documents to come from the group: it was frequently referred to during group sessions

and is, at the time of writing, almost one year after the beginning of the group, still displayed in the care office in the home.

Later, some of the items listed needed to be looked at again and explored in more detail, for example the meaning of the word independence as described earlier. However it remained a useful and very real document which enabled members to evaluate their practice in the light of the values agreed.

c) Early morning practices

When asked which areas of practice they wanted to look at first, the members of the group suggested three, of which early morning practices was one. The others, admissions and activities, were discussed later. At the time it seemed logical to start with what happened at the beginning of the day, but in retrospect this was such a large, complex area of practice, involving so many staff, that it might have been better to start with a smaller more discrete subject area.

The then current early morning practicses have already been described (see Chapter 3.5, page 103/4).Essentially mornings were characterised by early rising, at 6.30; tea later at 7 am. in a lounge; a distinct division of labour between night and day staff causing hurriedness and pressure; and breakfast at 8.30. In particular tea seemed to be an important issue raised by many staff and residents alike.

Many staff, including the officer in charge, wanted to change some aspects of what happened in the mornings, and at this stage various questions were raised. For example, what is a 'normal' getting up time for people of this generation; what time would residents like to get up; would staggered breakfasts be an answer; could tea be taken round to rooms; would residents stay up later if they got up later.

At this point the researcher over-estimated the group's ability to look critically at their own practice. They were not ready to change, and a suggestion that the group look at current practice in the light of the values agreed, in order to suggest change, led to a storm of protest from a few members in particular. The protest centred largely around the researcher's perceived lack of understanding of the constraints the staff worked under and the problems relating to night staff. Some members were interested in looking at changes, but it was obvious that the researcher had mis-read the stage the group was at and had attempted to move too fast and in consequence had made a few members at least feel threatened and defensive. It was also apparent that the night staff should be involved in this discussion, and a decision was made to invite them to the next meeting.

Mention should be made at this point of the importance of consultants to group leaders. Before the next meeting of the group it was necessary for the researcher to re-think her style and

approach and to adopt ways of starting where people were, rather than imposing her own desire for change on the group. Fortunately this was possible in the form of supervision during the week, and the following session was planned around participative exercises focussing not on residents' getting up but on group members' own early mornings. The exercises were designed to enable people to get in touch with their own feelings about the start of the day and thus hopefully to help them make the imaginative leap which is empathy to think what it must be like to be residents.

Three night staff attended the next session and readily agreed with the values the care staff had listed to guide practice. The task, of examining early morning practices, was explained again, and some acknowledgement of the difficulty of change was made.

The exercises proved very successful. The first one, focussing on what constitutes 'good' and 'bad' early mornings for individual group members, demonstrated clearly that people are different and have individual needs, which in turn linked back to the agreed purpose of residential care. Other values from the list were illustrated too, notably choice, respect and dignity. People began to discover that the values agreed upon were as relevant to how they wanted to be treated as they were to the residents: an important point.

The understanding generated by this exercise enabled the point to be made that values really should guide practice and then resources and other constraints should be taken into account, rather than the constraints determining practice. This began to have real meaning for people and the possibility of innovative ways of overcoming constraints became apparent.

The next exercise asked people to forget constraints for the time being and imagine they were residents themselves in the home. They were then asked in small groups to decide on an 'ideal' getting up to include such activities as waking, dressing, going to the lavatory, having tea, washing, making the bed and having breakfast. The results of this exercise were recorded on a large sheet of paper which was hung in the office for several weeks. The response again showed great individual variation and there was general agreement that the ideal arrangements people had described reflected the guiding values far more than the present practice in the home.

It was almost time to return to the real world with its constraints and difficulties and to make some decisions, but before that a third exercise was undertaken in which people were asked to write anonymously on a piece of paper, "What I hope we will decide to do is..." and, "What I fear we will decide to do is..." These sentences were completed, handed in and redistributed for reading out to the group. The responses were fascinating and

showed a far greater readiness to change and understanding of individual need than had been apparent the previous week. For that reason they are recorded in Table 3.4, on page 151.

Whilst some of these responses show quite clearly a need for routine, for example the ninth fear, or a desire for staff-centred practices, for example the seventh fear and the third hope, many of the others show an awareness of resident oriented practices and a desire to move towards them. The eighth hope, written in the first person, is rather moving and illustrated for the researcher the profound and rather humbling intuitive empathy many care staff have for the people in their care.

The fourth exercise, which was completed individually, asked people to look at the early morning activities listed in the second exercise, this time in relation to the real world rather than the ideal, and to make recomemndations regarding when, by whom, where, how and why they should be carried out (see Appendix 4 no. 6 for details). This exercise was undertaken between sessions as was the analysis of results. In general terms people thought waking should occur later than at present; toiletting should be at the individual's request and should be done with respect and dignity: tea should be taken to people's rooms or they should be given a choice of having it in their rooms or in the lounge; and dressing and bedmaking should be accomplished unaided where possible. Concerning washing and breakfast, no clear pattern

Table 3.4 Table showing responses to hopes and fears exercise

Hopes	Fears
1. To attend to the residents' needs before other chores.	1. Do without a morning cuppa, or by rearranging this have less time to listen, dress etc.
2. Not to call residents so early and give them a cup of tea in bed.	2. Have tea in bed.
3. Have a lie in if people want to, but not expect to be waited on after breakfast. Breakfast to be between 8 and 9 am, so as not to interfere with day staff's routines.	3. Tea in bed.
4. Allow residents tea in bed or in their rooms.	4. Stick to routines.
5. Give individuals more choice in their daily lives.	5. No choice for everyone - no matter what is decided.
6. Be allowed to stay in bed and have tea. Get up at leisure.	6. Time will always be the restraining factor in providing more emotional time for the individual.
7. Give a greater freedom of choice to individuals.	7. Have breakfast in bed with subsequent amount of soiled linen etc.
8. To remember I am old and can't always help myself. I hope a cup of tea will be available, but if I spill it I dread the consequences. I hope I will be given time to do any little chores which I am willing to do and not get hassled by cleaners or care staff to hurry out of my room.	8. Be kept to a timetable because of work to be done.
9. Have more time to get up gently and quietly. Time for the toilet, for a cup of tea in bed or bedroom, to wash, dress etc. No rush and time to listen.	9. Staggered breakfasts, as I would never know what time to attend the dining room.
10. Tea in bed and have time to talk to them.	10. Leave things as they are.
11. Introduce more flexibility and choice.	11. Call them earlier.

emerged, although only three wanted to retain breakfast as it was at that time.

Throughout the responses the importance of dignity, respect, privacy and choice was highlighted. In general the answers showed a desire and willingness to move towards more resident-oriented practices. However there was a tendency to suggest that the frailier residents be treated in more institutional ways, given less choice and so on. This was pointed out and members appeared to accept that these residents too had a right to freedom of choice. Another subject raised at this time turned out to be a fore-runner of the 'independence' issue. It centred around people only being allowed breakfast in bed if they were sick, and illustrated that the staff felt that they knew what was best for people. At this time the issue was raised, discussed a little an then dropped. It continued, however, to be raised in various forms, and became a theme running throughout the group sessions.

The time had come to begin to make some decisions about change. This proved, not surprisingly, to be difficult and time consuming. Constraints were raised again. One member said, "It's not as easy as you think," and this had to be recognised. On the other hand other members were thinking creatively around problems, having identified the direction in which they wanted to move, and this was an exciting development. Inevitably the

the decision-making spread over to the fifth meeting of the group. Nevertheless certain general feelings about the direction change should take had been established, and these provided a firm base on which to make more detailed decisions. At this time it was decided that the officer in charge should ask residents what they would like and that these views too would inform the decisions to be made the following week.

The next session started with re-calling briefly the 'ideal' early morning exercise. This was to help people focus on ideals and the agreed values to guide the decisions to be made, rather than starting with the constraints.

The officer in charge reported that many residents said they would like to be woken later than 6.30 and that the idea of tea in bed was generally welcomed, although the residents who at that time took the tea to the upstairs lounge were upset at the possibility of change and their potential loss of role. This was an important point and one which the group readily took on board.

Decisions were finally made, and crucial to their being made in the direction of more resident-oriented practice, was the negotiation of tasks being seen as shared by night and day staff. Much of the previous hurry had been caused by night staff having to complete tasks like getting people up, making

beds and emptying commodes before they went off duty at 8 am. Through negotiation it was established that many tasks could be seen as shared: as being started by night staff and completed by the day staff. This seemingly simple solution to hurried mornings in reality took a great deal of time and meant that the day staff, for example, had to accept that sometimes fewer beds would be made by 8 am. than was normal if more residents were sick and thus required more help than usual. Such a decision also required the two groups of staff to have a fair degree of respect for and trust in each other.

Finally it was decided to wake people at 7 am., with a cup of tea if they wanted it. Tea would also be served in the lounges if people preferred, and this ensured that the two residents who traditionally collected the tea trolley and distributed the tea would not lose their jobs. Bedmaking, emptying commodes and so on would be started by the night staff after they had helped those residents who needed it to wash, dress and go to the lavatory, and would be completed if necessary by the day staff. Breakfast would be at the slightly later time of 8.45, giving everyone a little more time.

These proposed changes appear fairly minor and they were indeed less far reaching and flexible than the researcher had hoped. And yet they represented for the staff a huge step: they had examined one piece of their daily routine and had decided to

change it to meet the needs of their residents better, most significantly by renegotiating the division of labour between two groups of staff in order to be more flexible and less staff-centred.

The officer in charge agreed to take the broad decisions made and to implement them when it seemed appropriate. The need to involve other staff, not present at the meetings, was acknowledged, as was the preparation of the residents and their involvement in the change. It was generally felt that a good task had been accomplished in the group and that the night staff's presence had been valuable in that issues had been able to be addressed and the two groups of staff had been able to communicate better.

The group membership then returned to the care staff only and the group went on to examine the role of the key worker. The officer in charge decided to leave the implementation of the new early morning practices until after Christmas, giving her time to work out the details and to prepare both staff and residents for the changes. Consequently the actual change did not occur until just before the tenth meeting of the group.

In retrospect the researcher should have allowed time for feedback about the change during this session, but informal discussion with the officer in charge and one or two of the other staff had suggested that it had gone remarkably well in their view and that over fifty percent of the residents had chosen to have

tea in bed. However a casual question about the change towards the end of the session led to a torrent of feeling about how it had gone. This was one occasion when it was apparent that group members did not feel free to initiate a change of subject in the group, despite the strong feelings evident. The researcher should have foreseen it but did not, and neither did the officer in charge. It was an interesting example of how people may have totally different perceptions of the same event. In fact some members of the group did think that all was well, others saw minor hiccups and others saw misunderstandings and significant problems. Clearly the issues needed airing and different interpretations explored in more detail. Much of the feeling again seemed to centre on the night staff and so it was decided to invite them back to the next meeting and try to explore and resolve the problems.

The following week began with many people, especially the night staff, denying there were any problems, despite the fact that it was acknowledged that any large scale change was likely to result in at least some short term misunderstanding and uncertainty.

In order to arrive at a common understanding of the new procedures the officer in charge went through them stage by stage. It became apparent that people had interpreted things differently and one or two minor unforeseen things had happened. Consequently a few small modifications were made and these were written up

in a manner with which everyone agreed. Finally an exercise was undertaken, in which each member of the group wrote down one good thing that had happened as a result of the change and one bad thing. The good things were generally about the more relaxed nature of mornings; the appreciation seen on residents' faces when they were offered a cup of tea in bed; and the fact that over half the residents were exercising their choice to have tea in bed. The bad things were far more specific and referred to particular occasions when things had gone wrong. For example one morning no-one put the boiler on for hot water and on another occasion a few tea cups had not been collected from rooms.

This exercise helped people to see the change in perspective: generally it was seen to be good: what had gone wrong were things that could be resolved and indeed were. As far as possible people clearly needed to know what their responsibilities were, who was to switch on the water boiler for example, but also important was the recognition that this more flexible way of working would mean that people's roles were sometimes blurred and that staff would have to see what needed to be done and do it, rather than see it as the province of one group of staff only.

Thus the first of what Kemmis (1981) refers to as the "loop of action research" was complete: the practice had been evaluated;

decisions to change had been made; the changes had been implemented; and the new practice evaluated again and modified. It was a good feeling, and yet it illustrates clearly the difficulties inherent in effecting change and the effort required on everyone's part, to bring about even small changes. If nothing else there was, however, tremendous satisfaction in the thought of over twenty five elderly people being woken daily with a cup of tea in bed.

d) The development of the role of the key worker

The development of the key worker role was generally acknowledged to be something that people wanted to do. In addition it was seen as being likely to encourage practices which would more accurately reflect the guiding values, since it began to break down the large resident group into smaller numbers and thus encouraged individual rather than block care.

The concept of the key worker is one that means different things to different people. In the Barclay Report (1982) it means someone to co-ordinate various agencies' involvement in one client. However within residential establishments the term is usually used to describe the system of one member of staff having some overall responsibility for a small group of residents. Again the extent of this special responsibility may vary from one member of staff simply bathing the same residents every week,

to a situation in which almost all the responsibility for several residents' care is given to the key worker. There is a delightful, although possibly apocryphal, story of a relative phoning the officer in charge of one home in the county to enquire about her mother's health. The officer in charge firmly stated that she had no idea how she was, but that she would go and ask the key worker. Clearly between these two extremes are various possible models of the key worker system. In order to enable the group to decide on the extent to which they wanted to develop their system, the researcher put all the responsibilities possible that she thought could be given to key workers on a large diagram (see Appendix 4, exercise 7 for details). In small groups the members explored the ideas and made proposals for their own system. Most people wanted a fairly extensive amount of responsibility to devolve to the key worker. Areas suggested included pre-admission work, record keeping, care programmes, time to talk and reviews as well as the more usual bathing and special interest.

This led to a discussion about talking to residents, in particular finding the time to do so and feeling guilty about 'just talking'. Most people acknowledged the importance of talking in relation to meeting needs other than those for purely physical care, and many agreed with the research findings that in reality most talk with residents is of a limited instrumental nature (see for example Evans et al. 1981). As a result of

this the group members agreed to try to find the time to sit and talk to one of the residents to whom they were key worker during the following week. This proved an enlightening exercise: some staff were rather directive in their conversations with residents, both in terms of deciding the content and in telling the residents what they should do. However others were more client-centred and some brought to light previously unknown information about people which had a significant impact on their present situation. The exercise also led to a discussion about how much information staff should have about residents and what confidentiality meant in the context of a staff team. In particular some care staff asked if they could have access to residents' files. It became apparent that the officer in charge thought there was no problem in this request but that at least one other member of her senior staff, possibly two, did not agree. This seemed to be one issue that needed to be resolved outside the group and the senior staff agreed to discuss this further, having heard people's views, and make a decision on it. This they did, with the social services officer, and eventually came back to the group with an open policy for care staff on personal files, with the understanding that if any particularly confidential piece of information was received it would be kept separately. An interesting example of this was of a previous resident who had had venereal disease in earlier life. This was seen as information which the care staff had no need to know and this was accepted.

The exploration of the key worker role had led to the identification of several areas which group members wished to pursue further and in more detail. They were:-

helping people: especially in relation to painful feelings

keeping records

devising care programmes

reviewing progress

pre-admission work.

A decision was made to look at these in turn in the new year, and the group broke for Christmas with sherry and mince pies, and a feeling that something worthwhile had been achieved and a lot still remained to be done.

The next session started with an exercise asking people to think about the characteristics of the person they would turn to for help (see Appendix 4, exercise 8). The final list was as follows:

People are different: start from where I am.

Caring

Discreet

Empathic, understanding

Time for me

Accepting of me

Self aware

Someone I respect/trust

Someone who listens and hears

Sees things my way

Does not judge

Honest.

Two members of the group said strongly that they would not want to talk about painful feelings. This led to a discussion about the wisdom of 'bottling things up' and to the acknowledgement that some people want to talk and some do not: back to individuality again. A listening and reflecting exercise followed (Appendix 4, exercise 9) and a decision was made to try to listen to residents more during the course of the following week. Most group members did this, some with moving results (see process section, page 134, for example).

Record keeping was the next on the list of areas to consider in relation to the key worker. The general principles of record keeping were outlined and the group then made decisions about the sort of records they wished to keep. Eventually it was agreed that key workers should:-

a. On admission write a pen picture of the resident from the information received.

b. Make notes in a diary of any significant events or circumstances regarding 'her' residents.

c. Once a month use these notes to form the basis of the home's official record for each resident.

d. Record decisions about care programmes for residents

and the conclusions of reviews in the files.

In discussing writing records, emphasis was placed on using descriptive rather than emotive language and on only recording what would be helpful to other staff and that which people would feel happy for the resident to see. It was decided that members should write a pen picture of one resident to practice these skills. Three members of the group did this and from them a general format for such pen pictures was derived.

Care programmes were the next item to be discussed: a method of drawing up a care programme was presented which was met with interest by the members. The question of having aims and objectives for residents led to the issue of 'independence' being raised again. Essentially the debate had to do with whether independence meant maintaining physical mobility for as long as possible with little concern for the residents' wishes, or whether it meant the resident determining for herself how she would like to live her daily life. Miller and Gwynne (1972) illustrate this well in relation to younger physically impaired persons, when they talk of the dangers of officiously striving for independence when someone may be nearing the end of his or her life. This point was made to the group and to some extent the danger was acknowledged. However the group members felt that they, the staff, should decide when to stop pushing physical mobility, not the residents. This point of view represented a significant attitudinal gap between the researcher and the

group members. However, given the participative and democratic nature of the research, all that could be done was to describe a different point of view: the majority clearly believed in 'gentle force'. One member of the group explained his position by saying it was like a family: the children were asked their point of view and were listened to, but in the last analysis the father made the decisions. He drew an analogy with the residents and staff. This essentially patriarchal attitude was generally accepted by the staff.

Such a view of independence and the role of staff in determining the lives of residents, clearly put limits on moves towards more resident oriented practices, which by definition involve resident autonomy and choice. It remained a block throughout, possibly because it was only at this late stage that the researcher was able to articulate fully the nature of the block. Had it become apparent earlier it might have been possible to devise ways of helping people examine their attitudes. As it was, it was a clear example of the resistance of attitudes to change. It also demonstrated how deep-seated attitudes affect practice.

Returning to care programmes: with the use of one of the residents described in the pen pictures, the group set out to devise collaboratively a care programme for one elderly resident. This proved a fascinating exercise and enabled members to think

co-operatively about how to solve problems. Specific decisions were made that various members of the group would undertake particular tasks with this person: ranging from arranging a medical review to asking her to coffee with another resident.

Decisions were also made at this time relating to reviews within the home; their frequency, and the involvement of key workers in them.

The final area of practice to consider, in relation to key workers, was their involvement in pre-admission work. A visit to the team leader had established that she was more than happy to encourage key worker involvement in pre-admission work. A brief summary of the literature about 'good' admissions was given, concentrating on the importance of adequate preparation and honest expectations. The group then looked at what the home should do in relation to prospective residents before admission, and where the key worker should be involved. This resulted in some interesting ideas, including the possibility of the staff producing a pamphlet outlining to prospective residents what life in the home was really like. Unfortunately ideas such as these had to be left in abeyance as time was running out. In general however it was agreed that key workers should be involved in visiting prospective residents before admission, and being present when they visited the home for a day or for a short stay. They could also help the resident

decide what to bring with her, prepare the room and the other residents for her arrival and, of course, be there when she arrived.

A fantasy exercise, asking people to close their eyes and imagine how they would feel as a resident driving up to the door of the home for the first time, was extremely useful in helping people to understand how residents would be feeling at admission. The members of the group showed great sensitivity to the feelings of prospective residents and some considerable insight into what would help at this time.

This constituted the rather hurried end of the period spent examining the role of the key worker. There was little time for feedback about the implementation of the changes agreed upon. The records were opened to care staff and pen pictures, diaries and records were begun. They proved almost immediately useful when one member of staff left and her successor took over an up-to-date set of records about the residents to whom she had an especial responsibility. The proposals relating to care programmes and pre-admission work needed time to put into operation and thus were not reviewed during the lifetime of the group.

e) The role of activities in the home

This subject too was hurriedly discussed in part of the final session. It would probably have been better to have left it out and finished the key worker system better, but several people had specifically asked for the subject to be covered. Luckily sufficient ground had already been covered in the group for members to see quickly the dangers of enforced block activities for all. The research findings, particularly in relation to arranging furniture to encourage communication, and the importance of providing opportunities for activity were briefly outlined. A brainstorming exercise of possible activities provided some useful ideas, and members agreed that choice, opportunity and small groups were probably important guidelines for future developments in this area.

f) Evaluation of the group sessions by the participants

The group members decided they would like to evaluate the sessions verbally. There was a general feeling that the group should have continued for longer; that there were still many issues to be addressed. However the officer in charge agreed to instigate fortnightly care staff meetings so that the process could continue, in a different form but using the research group as a model.

Another generally held view was that the experience had improved communication between staff and that they now felt more like

a team. This confirms the view of Willcocks et al. (1982) that involvement in decision making results in a more satisfactory work environment for staff than does a more traditional and hierarchical regime. Evaluating the changes that had occurred as a result of the group was more difficult since many of them were still not fully operational. However there was general agreement that the early mornings were better and that the members of the group looked forward to the continuing development of the key worker's role within the home.

One senior member of the staff asked for a summary of what are currently thought to be good resident-oriented practices to be included in the record of the meeting, together with a book list of accessible reading matter, and this was agreed. With this and amid general and mutual thanks for the opportunity to take part in the research group, the last meeting of the group finished.

3.8 RE-EVALUATION OF THE INSTITUTIONAL ENVIRONMENT

Section 3.6(Evaluation of the institutional environment) outlines how the Analysis of Daily Practice Schedule (Evans et al. 1981) was administered, and how the scorers, the social services officer and the researcher, arrived at an agreed score of 34.

Three months after the completion of the work with the staff,

at the end of May 1984, the two scorers went back to the home to administer the instrument a second time in order to see if any significant change had occurred in the insitutional environment.

The social services officer again asked four members of staff all the questions in the schedule and the researcher talked to the officer in charge and several other staff in addition to limited observation of current practice within the home.

Having filled in the answers to the questions independently, the scorers met to agree a final score. Interestingly the two scores were very similar (see Appendix 2 for the complete scoring schedule) the researcher scoring 21 and the social services officer 22½. This similarity was particularly gratifying given the relatively large disparity between the two scores before the research group started (researcher 38, social services officer, 24).

There were probably two factors responsible for the greater degree of consistency. Firstly, having previously decided the criteria for answering ambiguous questions, such as is there extensive use of sedation, the correct score became obvious to both scorers. Secondly, even where an objective criterion (such as 33% or above constitutes 'extensive') had not been agreed or was not possible, the second score could be determined

by whether or not there had been a significant change since the last time the schedule had been administered. Thus for example the fact that the furnishings (question 4:f1) had not changed meant that the score was the same as last time, whatever the individual scorer's view of their pleasantness.

Given the similarities in the two scores, the negotiation of an agreed score, of 22, was relatively easy. Again priority was given to observation of practice as opposed to reported practice if there was a discrepancy.

The areas of change were, with one exception, in the direction of more resident-oriented practices and overall the score improved by 12 points, from 34 to 22. The schedule items which indicated a change had occurred were as follows:-

1. Resident care

a1. Do residents have a choice of when they are bathed?

Overall the opportunity of choice, with the development of the key worker system, and the greater awareness of the importance of individual freedom of choice, was seen to have increased significantly.

d1. Can residents choose when to go to bed?

Again this was seen as an area in which choice had increased, but see below.

d2. Do staff attend promptly when residents need help retiring?

This was seen as an area in which staff were more sensitive to individual residents' needs, but see below.

e3. Are residents brought tea if they wish?

This was one of the most concrete examples of change having occurred as a result of the research group.

(total section improvement in score: 4)

2. Resident autonomy

b4. Have the majority of residents personalised their rooms?

There was a general feeling in the home that this had improved and observation appeared to support this view.

e1. Do residents have access to tea making facilities?

This was the one area in which the home became less resident-oriented during the research period. The tea making facilities were never really adequate and had eventually been removed prior to their being installed in a room especially geared to tea making. The second administration of the schedule corresponded with the period during which no facilities were available at all.

f2. Are other areas open to residents?

At the time of the first scoring, some areas were

being looked at critically in terms of resident access.

By May, access was being encouraged more.

(Net improvement in score: 1)

3. Resident/staff interaction

a3. Do staff regularly communicate with residents for social purposes?

There was general agreement that a great improvement had been made in this area.

c3. Do staff avoid demonstrating infantilisation of residents in their attitudes to them?

Again the research group was seen to have heightened staff's awareness in this area, but see below.

(Total section improvement in score: 2)

4. Organisational practices and features

b2. Do staff and residents meet to discuss issues?

This was seen as an area which had increased significantly.

c1. Are there regular staff meetings?

At the time of the second scoring staff meetings, in addition to the research group, had been resumed.

c3. Do staff control their daily work routines?

The research group was seen as having contributed

directly in this respect, helping staff to evaluate how they accomplished their tasks and giving them the opportunity to negotiate changing them.

g1. Are visiting times unrestricted?

The offending notice on the front door had been removed.

h3. Are residents consulted before outings/functions are decided upon?

It was decided that consultation had increased in this area.

(Total section improvement in score: 5)

Overall this change in score from 34 to 22 was a gratifying one, which confirmed the feelings of the staff, the officer in charge, the social services officer and the researcher that the institutional environment had indeed become more resident oriented (see following section). However, this optimistic view of the changes needs to be viewed with caution since the period of observation at the time of the second administration was far shorter and covered less of the waking day than that which preceded the first. As on both occasions the scorers scored according to observed practice if it conflicted with reported practice, the chances are that the second score gives a more resident oriented view of the home that the first, which included

several scores based on observation rather than reported practice. Areas of apparent improvement in which change may not have occurred are covered in questions 1:d1, 1:2d, and 3c:3. In retrospect this can be seen as a methodological weakness in the comparison of the two scores. It arose because the researcher saw the period of observation before the group sessions as distinct from and having different purposes from the administration of the schedule. Either the systematic period of observation should have been repeated or both scores should have been based only on the practices reported by a range of staff. Even so, assuming the second score was over optimistic in the areas outlined above and that actual behaviour had not changed, the score would still have improved from 34 to 25: nine points instead of twelve.

Conversely there were some changes which did occur which did not feature in the Schedule score, but which in the researcher's view did result in a more resident oriented environment. For example the decision to wake people at 7 am. instead of 6.30, at the same time as not stopping people from rising earlier if they wished, led to an extension of choice in the home albeit small and a move towards a more normal lifestyle. Thus the Schedule can be seen as incomplete, in that it did not record all the changes that occurred.

The Schedule was used in an attempt to monitor, in a relatively objective manner, any changes in the institutional environment

which occurred during the research period. At one level it would appear that this had indeed happened, in that the change in the Schedule scores suggested an increase in resident orientation which was confirmed by the more subjective views of the participants in the research. However it is the researcher's contention that in reality the scores themselves were open to subjective judgements. The problem of observation of practice has already been mentioned in relation to its being less detailed for the second scoring, but it is problematic in other respects also. Does, for example, the observation by the researcher of one member of staff deliberately witholding medication from a resident who wanted to go to bed early because he irritated her by constantly asking, justify saying that staff generally do not attend promptly when residents want to retire (question 1:d2)? The researcher had no way of knowing how widespread this practice was or even how typical it was of that member of staff. All staff on the first and second scoring **said** they attended promptly to people's request to retire. At the time of the second scoring the researcher did not observe the home at night when the same member of staff was on duty and so the score appeared to have improved in this area. Another question, 3c:3, referred to whether the staff infantilised residents. This involved even greater scope for subjective judgement since what constitutes an infantilising attitude had to be decided by the scorer. Again the researcher, in her view, observed at least one member of staff infantilising residents during

the period of observation, but none before the second administration of the instrument and so again the score appeared to show increased resident orientation. Partly these problems could have been overcome by having a more formal observation period before the second showing, but even so it would have been impossible to replicate exactly the same staff on duty in the same situations as before; and even if one could have done that, there would have been no way of knowing if that was typical of practices within the home.

It is the researcher's contention therefore that it is not surprising that the Schedule score corresponds with people's subjective judgements about the changes, since essentially the scores are little more than the subjective views of the scorers and the staff they interviewed translated into quantifiable terms.

The two schedule scores lend an air of scientific objectivity to the study, and yet in the researcher's view the Schedule is relatively imprecise and subject to so much judgement as to render it no more helpful than any other necessarily incomplete subjective view of the situation. This is not to infer that the Schedule was of no value whatsoever or that it was not possible to evaluate satisfactorily the changes that occurred.

The Schedule was useful in that it provided a fairly comprehensive,

although possibly incomplete, checklist of items which suggested resident or institution orientation. These items encouraged the researcher and the staff to examine specific areas of the home's daily practices fairly rigorously and this was helpful. In addition the change in score served to legitimate the consensus view that positive change had in fact taken place and the size of the difference in the scores gave staff and researcher alike a feeling of having accomplished something tangible and worthwhile.

On the other hand if the researcher is right in saying that the Schedule showed little more than sometimes arbitrary aggregate subjective views of the changes in the home, that is not to say that those subjective evaluations have no validity. All of the people involved in the research, the staff, the officer in charge, the social services officer and the researcher, evaluated the changes carefully, using observation and feedback from residents and staff to help them. The fact that their conclusions cannot be quantified does not invalidate them. For all the people involved significant changes did occur: they had meaning for the participants in the research and in their view the changes were for the better. These evaluations form the basis of the following section.

3.9 ANALYSIS AND EVALUATION OF THE EFFECTIVENESS OF THE RESEARCH GROUP

The previous section suggests that the institutional environment did become more resident oriented than it was before the research group was set up. At least some of this improvement can be attributed directly to the changes introduced as a result of decisions made in the group sessions, for example the introduction of early morning tea in bed.Other changes suggest a growing awareness on behalf of the staff of the importance of choice and individuality, which may well also have occurred as a result of the group sessions. This view, that staff had become more aware, was supported by a memo from the social services officer to the researcher following the second administration of the Analysis of Daily Practices Schedule (Evans et al. 1981) which read, "I found it interesting interviewing (the staff about the items in the Schedule) again as I felt that more thought was given to the answers this time, showing greater awareness of the issues, even if change had not yet taken place."

It must be remembered, however, that the officer in charge, quite independently of the researcher, had wanted to move away from institution-oriented practices, and that changes in awareness may well have occurred as a result of such general development within the home, rather than as a direct result of the research group.

The group members' views of the sessions have already been reported (at the end of section 6). Their view in essence was that the group sessions had been helpful in enabling them to begin to look critically at their own practice and that the changes they had made were in the right direction. They also thought that the project had enhanced their ability to work together as a team and to feel part of a team. Finally they saw the research group as having provided them with a model of working together which could be continued beyond the life of the research group.

Other people who evaluated the group sessions at this stage were the officer in charge and the researcher herself. The officer in charge wrote a report summarising her perceptions of the effect of the group at the end of the group meetings. She saw the changes that had occurred being as a result of the group work with the staff. She noted that the changes, although not dramatic, had nonetheless involved a great deal of preparation and thought. It was important that both residents and staff were involved in the changes and that their fears and apprehensions were acknowledged. In particular she mentioned the new early morning procedures which both staff and residents saw as beneficial in that it had made mornings more pleasant and less hurried. One member of the night staff reported that she went home after the first morning feeling that she had done her job well and that there was more time for the residents.

Other night staff too had reported an increasing level of job satisfaction.

The development of the key worker system was also commented upon in the report. She saw its main advantages as stressing the importance of individuality and increasing skills and confidence in record keeping and care programmes.

In summary, the officer in charge thought that the staff were, as a result of the research group, working more as a team than before: a team which was increasingly aware of the residents being individuals with needs.

Some four months after the end of the group sessions the officer in charge and the researcher went to see the Director of Social Services in the county and other senior staff interested in the work undertaken to report on its progress. A paper was prepared to present to this meeting in which the following changes were identified by the officer in charge:-

1. Fifty percent of residents now choose to have tea in bed.
2. Residents are woken later than they were.
3. Mornings are less hurried, more relaxed.
4. One more resident and several newly admitted residents make their own beds.
5. Records and diaries are kept by key workers.

6. Fortnightly key worker meetings are now set up.
7. Staff participation in extra activities has increased.
8. There is now a more active notice board.
9. There is more awareness of the importance of recognising the individuality of each resident.
10. There is more feeling of working as a team.
11. Staff talk to residents more.

Whilst some of these changes might have occurred without the existence of the research group, it was generally agreed that the group sessions had led to most of them being effected.

The researcher's evaluation of the work with the staff was inevitably affected by the views of others and by the results of the Analysis of Daily Practices Schedule. It was clear that changes had occurred and that they were largely in the direction of more resident oriented practices. This was particularly pleasing given the relatively institutional regime the staff were used to and the lack of training amongst the staff group. What was especially gratifying to the researcher was the thought of over twenty five elderly people being woken a little later with a cup of tea each morning, and the general consensus that the awareness of the importance of individuality had increased considerably amongst the staff.

On the other hand there was on occasion a feeling of frustration at the length of time change took and the smallness of the

changes agreed upon. For example waking elderly people at 7 am. instead of 6.30 is clearly a move towards a more normal lifestyle, but bears little relation to people being able to get up when they wish, as they would at home. This decision, to wake people at 7 am., was perhaps illustrative of a much bigger issue relating to control of daily life. Whilst the staff said they believed in choice and self determination, in practice they were prepared to give little control of daily life to the residents. Self determination, it was feared, would lead to abuse, to chaos and to staying in bed all day and thus to rapid physical deterioration. In the last analysis staff thought they knew what was good for people, hence the pervasive acceptance and use of 'gentle force' within the home.

Thus in general terms the researcher's view was that within the attitudinal framework that existed amongst staff, changes had been made towards more resident oriented practices; but that the attitudinal framework itself, despite humanising and individualising influences, remained essentially a controlling one.

This is not to criticise the staff, or to denigrate the very real changes that were effected, rather it illustrates the difficulty of bringing about major change when it involves, as it inevitably does, attitudinal constructs about residents and the role of staff in relation to them. A more detailed

exploration of this point of view, including an examination of the work of Dartington, Miller and Gwynne (1981) on attitudinal constructs, is made in the next chapter.

In relation to the methods employed, the researcher was, in the main, happy with the form the groups took. On one occasion the researcher's own desire for change led to her trying to move faster than the group members could go, but this was a lesson painfully learned in the second session and one which was not repeated. The use of participative exercises was invaluable in helping people articulate their views and feelings and very often once these were out in the open it was possible to resolve difficulties and to move quite rapidly towards decisions about change. The tension between enabling people to make their own decisions and giving them information appeared to be resolved successfully, by the emphasis being on enabling and information and theory only being brought in when they were actively sought or when they illustrated a current issue in the group.

Preparation for change was recognised by the researcher and the group as important, both for staff and residents. Evans et al. (1981) found that two crucial factors in achieving more resident oriented homes were the ideological commitment of the officer in charge to resident orientation and her ability to move towards such practices by consultation and communication. Certainly the research group was successful in involving all staff in decision making and enhancing communication between

them. The use of an agreed set of values to guide practice helped inform the communication within the group and, within the attitudinal framework referred to above, commitment to resident orientation did increase during the group's lifetime. Even more importantly, this commitment was in several instances translated into practice, as can be seen by the evaluations of all the people concerned and by the supposedly more objective Analysis of Daily Practices Schedule scores.

3.10 POSTSCRIPT

In the summer of 1984, less than six months after the end of the action research undertaken with the staff group, the officer in charge left the home to take up a similar position in a new home built on the bed-sitting room principle. A new appointment was not made immediately and during the interim period the home was managed on a part-time basis by the officer in charge of a neighbouring home in conjunction with the remaining senior staff.

When the new officer in charge was appointed, she expressed interest in the work that had been done and a meeting was subsequently set up between her, the social services officer and the researcher in the spring of 1985. Like her predecessor, she was glad to use the experience of the research group if it would help her achieve the changes she wanted in the home. Thus agreement was made at this meeting that the researcher

would return to the home and review with the staff the work that had been undertaken, receive feedback on the present situation, and offer to come back on at most two further occasions to explore any current issues.

Several new appointments had been made in the home since the previous head had left and so the staff group which met at the review session included people who had not been part of the original reserach group. The review of the work undertaken was thus partly with people who remembered it well, and partly with those whose knowledge of it came from hearsay and the values poster, which was still usually displayed in the care office, but which had been brought to the meeting as a symbol of the old group and its work. Again it provided the focus for useful discussion before the researcher went on to summarise the changes that had been initiated by the group. This review part of the meeting was concluded by the researcher sharing some of her own conclusions about change towards more resident-oriented practices within the group, focussing particularly on her view that self determination was an issue that had not been fully explored and accepted within the home. Finishing on such a controversial note was a calculated risk which had previously been agreed with the officer in charge who was keen to put the issue of residents' rights on the agenda. Interestingly some attitudinal shift appeared to have occurred as this comment was met with fairly general agreement and no-one claimed that staff alone knew what was best for residents. The reasons

for this are open to conjecture. One possible explanation could have been the new head's views on the subject and those of the new RC04, both of whom were more prepared than their predecessors to express strong committed views publicly. Together these two had, it seemed, brought about a considerable change in the feel of the senior staff group.

The second part of the meeting consisted of the staff reporting back on the current situation within the home, in relation to the decisions made by the research group. The general view was that the period without an officer in charge had been a difficult one and that many changes had not been sustained during this time. This may well have been because of a lack of real commitment to resident oriented practices on the part of one or two of the remaining senior staff. Without a permanent officer in charge to encourage and develop such practices, the staff had been unable to sustain them and may even have been overtly discouraged from continuing with them. The early morning practices had, however, been continued but the kew worker developments had in part either not taken place or been discontinued. This experience corresponds with Kemmis's (1981) contention that action research loops need to be completed by being brought back to the group for re-evaluation, for change to be likely to be sustained. It also illustrates the importance of the officer in charge in providing direction for change. Despite these set-backs however commitment to change in the direction

of more resident-oriented practice was strong and many people welcomed the opportunity to address the issues once more.

A decision was easily reached to continue the group for two further sessions and it became apparent that two pressing areas of concern were residents' rights and the further development of the key worker system, building on the work already started.

As had occurred previously, a record of this meeting (and the two subsequent ones) was sent to the home where it was put on public display in the staff room.

The second meeting took place two weeks later and centred upon residents' rights. Group members were asked to identify rights they had which residents would have to give up when they came into the home. They were also asked to choose the two rights they as individuals would find most difficult to give up. The two most frequently mentioned were 'the right to live with people I choose' and 'the right to get up when I like.' This was followed by a brief summary of some of the social work literature on rights, notably the work of Clark and Asquith (1985) and Clough (1981) which was put onto posters and displayed on the wall. This information was received with great interest and a request was made that the posters remain in the home.

A general consensus emerged that clients' rights were curtailed

unnecessarily within the home and that these should be extended at a further meeting between the officer in charge and the care staff.

It was apparent at this stage that the staff were now functioning as a staff team not as an action research group. There was no suggestion of these proposed changes being referred back to the research group and neither did this seem appropriate given the very temporary nature of its re-establishment.

The third and final session focussed upon the further development of the key worker system. It was clear that many of the staff regretted that some of the agreed changes had not been sustained in the period when the home was without an officer in charge, and equally there was a strong feeling that the time for change was right. Because of this general commitment, together with firm leadership from the officer in charge on this subject, a series of no less than eight areas were quickly identified where change was required. In some cases these were changes agreed upon before, such as free access to files and the involvement of key workers in pre-admission work and reviews, but in some cases decisions were made which went beyond earlier discussions, notably that key workers should call the doctor to a resident and only later inform the senior staff. Again the ease with which this decision was made suggested that the officer in charge had already begun to make her views felt in the home. Whilst two or three staff who were fairly resistant

to change remained in the group it was apparent that their approach was no longer in the ascendancy.

It was recognised and acknowledged at the end of this final session that the changes that had been instigated would result in a home run on more democratic lines. Some power was being devolved from senior staff to the key workers and similarly residents were to be afforded more control over their daily lives. The view was expressed that this would result in increased job satisfaction for staff and a better quality of life for residents; a view confirmed by the research findings of Willcocks et al. (1982).

In general terms it was a positive experience to return to the home in such an unforeseen manner. The news that the officer in charge was to leave so soon after the completion of the action research had been disappointing given the potential for further development within the staff team. Subsequent events seemed to indicate that the disappointment was not groundless. However, with the appointment of a new officer in charge equally if not more committed to resident-oriented practices and certainly more prepared to express her views strongly, the staff group appeared ready and able to start working again. What was particularly exciting was that, having started, they seemed to consolidate previous learning and move ahead with considerable speed.

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CHAPTER 4

THE FORMULATION OF HYPOTHESES

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During the life of the original research group the researcher was increasingly aware of both progress being made towards resident orientation and of an impasse being reached which focussed in the group around the use of 'gentle force'. The block seemed to be attitudinal, and also appeared difficult to articulate or to understand satisfactorily. At the same time it seemed to be a pervasive attitude and a crucial one to understand in the quest for more resident oriented practices.

At its heart the problem appeared to centre on a 'Less Than Whole Person' attitude towards residents: a concept outlined by Dartington, Miller and Gwynne (1981) with which the researcher was already familiar. Their work was primarily in relation to attitudes towards younger physically impaired people, but they maintain (page 16) that their analysis is also applicable to elderly people in care and this certainly appeared to be the case.

Dartington et al. (op cit) maintain that staff's inability to come to terms with residents' physical dependence **and at the same time** acknowledge their right to be autonomous human beings lies at the centre of the difficulties institutions have in being resident oriented. They say, (page 64) "This reality, that disabled people have choices in their lives

and with help can have autonomous personalities separate from the personalities of those on whom they are physically dependent, has not been fully realised". In illustration of this point they continue, "Choosing when you get up, go to bed, when you eat, what you eat and the way you eat it - these are one might think simple things to get right ... and yet ... they are so important to the individual that they are the most ready examples given ... of a better care system. **For such basic freedoms it seems it is necessary to move heaven and earth."** The experience of this research project would seem to support this view, as would Willcocks et al. (1982, page 143) who argue that, "It is in the execution of the most basic and personal of activities, for example eating and bathing, that staff intervention is most marked."

Dartington and his colleagues believe that the explanation for this basic difficulty lies in the attitudinal constructs regarding disabled people and their relationships with able bodied people, held by the staff of residential homes and by society generally. They maintain that society has an inherent difficulty in dealing with 'damaged' members in terms of us/not us and same/different dimensions, so that it is never clear whether society's objectives towards them are custodial or therapeutic. Attitudes are thus complex and ambivalent in that people often think, do and say different things at the same time in relation to people with impairments. Nevertheless such

attitudes, however inconsistent, are functional insofar as they serve to justify behaviour, support existing practice, reinforce the staff's sense of worth and explain it to the outside world.

Society's attitudes to people with impairments are thought by Dartington et al. (1981) to fall into just four basic attitudinal constructs which regulate transactions between disabled people and those who are able-bodied. None of them, in their opinion, is entirely satisfactory in that none can accommodate both physical dependence and personal autonomy as suggested above.

It is proposed to examine these constructs and use them to analyse what happened in the home in relation to the staff's unwillingness to give residents much control of their daily lives, and the pervasive acceptance and use of 'gentle force' within the home in relation to such 'basic freedoms' as when to get up and when to eat.

The first attitudinal construct is named **Less than Whole Person** (LTWP). This construct emphasises the differences between residents and staff. The staff have obligations to 'look after' the impaired residents who in return must accept their inferior and supplicant position, which will involve them in being depersonalised and infantilised as well as having little personal

autonomy. The inequality of the relationship is thus justified and legitimises the model of care employed which Dartington et al. call the **warehousing model**. The "defensive dynamic of the inner worlds of the carers" (Dartington et al. 1981, page 118) is seen as the key to this attitudinal position. In order to cope with their own feelings of inadequacy and lack of self worth people project these attributes onto impaired or elderly residents, seeing them as less than whole and thus enabling them to perceive themselves as strong whole people who do good, thereby confirming their worth, by looking after the unfortunates, for whom some responsibility and obligation is felt. Risk taking is minimised since failure would lead to staff feeling guilty rather than strong and in control. Residents are therefore treated in routinised ways, since the staff know what is best for them, and this renders them dependent on the institution, which provides further 'proof' of their less-than-wholeness.

Liz Ward (1980) illustrates this construct well when she says, "Failure to allow participation in basic need fulfilment acts as a depersonalising factor. Collusive dependency arises, the enforced helplessness of the clients evoking strong parental feelings in the workers, who in turn only function at their best when 'looking after' other people. As a spin off, the residents and the workers grow heavily dependent on the institutional routine, which in severe cases takes over as the principal

reason for the unit's existence. When this happens 'getting everything done on time' becomes the real objective, regardless of objectives that may be formally described."

In essence then the LTWP construct can be seen as accepting the dependency needs of clients but denying their needs for autonomy. The need for physical care may lead to a person having to accept such provision of care but the 'collusive dependency' described above, which is a necessary part of such care leads to total dependence on the institution. Dartington, Miller and Gwynne (1981) say, "Those on the receiving end have to obscure any sense of wholeness and present themselves as 'altogether damaged'." Such care they argue in brutally explicit terms represents 'social death' for the residents: that is the period between stopping being a whole autonomous person in the community and physical death. Residents who fight to retain their individuality in such regimes are seen to be difficult and subversive. Studies of ill treatment in institutions suggest it is often such residents who are 'punished' by staff for refusing to accept their dependent role, and thereby demonstrating the staff's superiority and wholeness.

As a result of public conscience about successive scandals in institutions, Dartington et al. suggest that a liberal protest against the LTWP construct emerged: The **Really Normal** construct (RN). RN emphasises not the difference between disabled people

and those who are able bodied but the sameness: their shared humanity. Instead of dependence the emphasis is on independence, to be attained through treatment, aids, labour and willpower. The implication is that independence is the normal state of able bodied people and therefore if disabled people could attain it problems of boundaries between the two groups would disappear. However the term Really Normal implies also an absence of disability or frailty and thus elements of denial of dependencey needs can be seen to be present, often associated with ideailisation. Nonetheless there is an egalitarianism associated with this construct which is amplified by the two groups' shared rejection of the LTWP construct. Residents' autonomy needs are thus catered for, but their needs for physical or emotional dependency may remain unmet.

The recognition that autonomy **and** dependency needs needed to be acknowledged led to a third attitudinal consturct: **Enlightened Guardianship** (EG). The term essentially summarises the staff's position in relation to the clients, who in return for such enlightened treatment are expected to adjust realistically to their impairment. For example it rejects the infantilisation of LTWP but retains its sense of responsiblity to clients; it acknowledges the drive towards independence seen in the RN construct, but adds that this should be realistic in the light of the impairment. In essence, however, what is seen as realistic adjustment is defined by the staff who are ultimately recognised

as knowing best, as illustrated in the term guardianship. Thus if challenged this construct can quickly revert to LTWP.

The fourth attitudinal construct, entitled **Disabled Power** (DP), is seen as having parallels with the growing political consciousness of the black and feminist movements which assert that being different has positive value, for example black is beautiful. This is in contrast to the RN position which stresses sameness with the majority and EG which emphasises adjustment to normal society. DP, unlike all the other constructs, comes from disabled people themselves, albeit a minority. It can be characterised by, "I am a whole human being and as such have the same legitimate rights as all others, disabled or not. It is society that is handicapping me by depriving me of these rights." (Dartington et al. 1981).

The DP construct can be seen as being in opposition to the other three constructs. It threatenes LTWP because it asserts rights rather than privileges; it rejects EG because it refuses to accept able bodied values in relation to disabled people; and it threatens the liberal adherents of RN in that it asserts difference is all right, showing up the "patronising element lurking behind egalitarianism." (Dartington et al. 1981).

However, since it relies on opposition to the other three for existence, the DP construct cannot mediate the relationship

between disabled people and the able bodied, except in confrontation. Nevertheless it is argued that the very existence of the DP construct has two immediate effects. Firstly it pushes liberal RN people to the EG position, since it refutes their thesis by asserting and valuing difference. Such people therefore are pushed into the EG position of trying to understand and at the same time asking people to be realistic. Secondly EG becomes less positive as DP refuses to be 'realistic' or to 'adjust' and thus pushes EG into 'we know best' which quickly begins to look like the LTWP position.

Dartington, Miller and Gwynne (1981) maintain that the majority of transactions between disabled people and others is mediated through these four attitudinal constructs, sometimes through one particular construct but often through more than one at the same time, showing society's ambivalence. They argue for a redistribution of attitudes: accepting on the one hand people's dependency needs without giving up at the same time their need for personal autonomy in their daily lives. At present the existing attitudinal constructs do not allow for both. The only one to accept the need for physical dependency is LTWP and that requires giving up all personal autonomy as well. Personal autonomy is advocated by DP but when it is argued stridently it forces others to respond in a way which emphasises less-than-wholeness: ultimately LTWP again.

Such inherent conflicts in our attitudinal constructs say the authors are apparent in society's inconsistent approach to provision. Residential care itself can be seen as an expression of LTWP (the resident being seen as no longer able to cope) and although RN noises may be made ('it is the residents' own home and we must treat it as such') the philosophy of the home in reality will probably be EG, with the emphasis being on realistic adjustment as defined by the staff. DP seems by definition to be incompatible with current residential provision and certainly one meets few residents who assert that old is beautiful and that it is society and the staff who are handicapping them. Perhaps they would not last very long in the home if they did. It is interesting that when the officer in charge saw the researcher talking to the resident who said the home was like a prison camp, she said that she hoped the researcher would not just talk to him about views of the home, since he was a 'difficult' man.

Turning again to the home in which the research was undertaken, it seems to the researcher that the home could be seen at various times to be adopting both LTWP and EG attitudinal constructs which regulated relationships between staff and residents. The recognition of the importance of choice, individuality and dignity and the development of the key worker system showed a rejection of the total dependency and infantilisation of LTWP. However, not far beneath this EG attitude was the conviction

that the staff knew what was best for the residents, as shown by the pervasive acceptance and use of 'gentle force.' When the researcher pointed out the inherent inconsistencies between choice and gentle force the EG began to look very much like LTWP, and gentle force won with no trouble at all.

It is interesting to recall that one of the main occasions on which this issue was addressed in the research group was in relation to frail residents having the right to decide when to get up after an illness. The researcher asked why a resident could not retain the personal autonomy to make decisions such as these, particularly towards the end of her life when she might decide that she no longer wanted to face the struggle of getting up at 7 am. each morning: she might want to choose physical dependence. The response from the staff was strong. The consensus was that they knew best; that client self determination in such an area would lead to people taking advantage, staying in bed all day and ultimately deteriorating physically. They would then be seen as not doing their job properly. Interestingly this position of the group's emphasised enforced physical independence and emotional dependence: the opposite of what Dartington,Miller and Gwynne advocate.

This response was almost identical to one described by Dartington et al. (op cit). There, staff, hearing about a unit trying to meet physical dependency needs at the same time as encouraging

personal autonomy, expressed the view that it would lead to dangerously autocratic residents who would, if continued to be 'allowed' control of staff, destroy them both. In other words the clients could not be trusted to control their own daily lives: staff knew best.

These incidents demonstrate how the **authority** of staff remains a crucial issue in relation to both LTWP **and** EG constructs. The 'defensive dynamic' described above dictates that workers must remain responsible, must see themselves as knowing best, because they have projected onto the clients, it is argued, their own fears of being less than whole. "How much," say Dartington et al. (1981), "are disabled people made to feel inferior or have their autonomy undermined in order that others may feel better?"

Resident orientation, it seems, it not easily achieved. Roger Clough (1981) describes the residential task as being "both complex and skilful" and comprising staff encouraging "the individual to decide how she wants to live." He sees the encouragement of emotional independence as being particularly important for residents who are of necessity physically dependent on staff, but recognises that this may not meet staff's needs to 'look after' people. In this he echoes the concerns of Dartington et al. (1981) and Willcocks et al. (1982) who talk of the "general ambivalence which surrounds the nature

of the caring task and the role of residential social work ... In particular there is a conflict between social work values and a medical model of care."

Goldberg and Connelly (1982) say, "In the battle against the inherent dangers of the total institution... **the ordinary values of everyday life** have been stressed ... opportunities for privacy, a degree of choice over daily activities the preservation of independence and autonomy as far as one's mental and physical capacities allow ... and the right to take risks." Essentially this is what resident orientation means. Ever since Townsend's (1962) and Goffman's (1961) early work, much of this has been known and yet an extensive recent study by Godlove et al. (1982) of actual practices in elderly persons' homes presents, according to Booth (1982), "A bleak picture that suggests that over 20 years of research-based criticism has done little to change important aspects of institutions."

What is wrong therefore is known all too well; what is desirable is also known and is in essence the ability of residents to lead as self-directed a life as possible even if they are physically or mentally frail. The PSSC (1975) for example recommended the provision of 'minimal routines' in other words "policies and practices designed to leave as great an area of freedom of action open to residents as possible."

Apart from being desirable ideologically (see for example Ward 1980) in that such an approach corresponds with generally held views of the rights of people to determine their own lives, such an approach has also been shown to enhance people's well-being: "Consumer satisfaction is enhanced when personal identity is respected and individual rights and freedoms are asserted." (Willcocks et al. 1982). Thus the relationship between the quality of the environment and the quality of life for residents has been established.

Dartington, Miller and Gwynne's work (1981) is useful in that it helps to explain why this knowledge of what is desirable and is so often the basis of policy documents is so difficult to translate into practice. The LTWP attitudinal construct prevents resident oriented policy being put into practice, since inherent in the construct is the necessity of staff to do things to people in order to feel whole themselves: what they call 'the defensive dynamic of the carer.' Real resident orientation requires giving at least some of the power to determine daily life to the residents themselves and this is incompatible with a LTWP attitude.

Currently, however, resident oriented values and practices are generally extolled in the social work press and in training courses. Even if staff have never heard of Goffman's or Townsend's work they will know that independence, choice

and dignity are values currently thought to be important.

The resolution of this inherent incompatibility between LTWP and resident oriented values seems in many instances to take the form of paying lip service to choice and independence whilst in reality redefining the concepts so that they can co-exist more comfortably with a LTWP construct. Thus, for example, independence changes in meaning from self determination to a sort of enforced physical independence, in which people are kept going physically, sometimes in quite officious ways, for as long as possible, irrespective of what people want, since the staff know what is best for them. Strangely this change in emphasis has meant that independence has come to mean its opposite: enforced physical 'independence' can only be achieved by residents becoming dependent on staff making decisions for them 'for their own good'. In other words, 'independence', in the sense of keeping people going physically, reinforces the defensive dynamic since it confirms that residents are less than whole and that staff know what is best for them. At the same time however lip service can be paid to progressive notions such as independence, which Davies and Knapp (1981) define as a 'state of self reliance'.

Other values can be redefined too in order to render them compatible with a LTWP construct. For example in the research home the practice of having tea downstairs at 2 pm. rather

than immediatly after lunch was explained by some staff in terms of giving people choice. In fact the reason was to increase the likelihood of participation in activities which were seen as good for people. The choice was not real: it was not simply a choice of whether to have tea or not, but whether to have tea accompanied by an often painful walk and an activity over which there was little consultation, or not have tea and stay in the lounge. Both 'choices' emphasise less than wholeness: the first in that it assumes people will only do what is good for them if they are bribed and cajoled and the second in that it punishes people for not making the 'right' choice. Real choice, according to Booth's study (1982) is generally confined to "Matters which clearly do not involve any risk to themselves (the staff) or to the orderly running of the home."

Through such redefinition, almost bastardisation, of such concepts as independence and choice the dilemma between LTWP and resident oriented values can be resolved, without the issue of residents' rights to determine their own daily lives ever really being addressed or thought through in terms of staff/resident roles. The essential construct is LTWP, but lip service can be paid to resident oriented values.

The LTWP construct clearly has implications for the relationship between residents and staff and their respective roles. The expectation is that staff look after, do to, and know what

is best for residents. Residents in their turn are expected to reciprocate by being done to, receiving services submissively and preferably gratefully. These role expectations help explain why dependent confused or institutionalised residents are often preferred by the staff to those who the home **says** it is aiming for: those who exercise individual choice and who demand to be treated as responsible adults. Evans et al. (1981) for example records that 71% of staff questioned, who expressed a preference, said that they preferred working with confused residents. Thus the 'good' residents become 'bad' and vice versa: a strange paradox.

The very act of coming into care seems to change someone from a person with rights and responsibilities into a resident or client who must by definition be less than whole. Such labels depersonalise and stigmatise and affect disadvantageously the way a person is percieved by staff and society generally. In the case of elderly people this process is amplified by the ageism inherent in our youth oriented society. Once in care the use of infantilising words such as 'pocket money' and routinised care further serve to emphasise the less than wholeness of such people.

In essence then it seems as if the policy is often right but that deeply held LTWP attitudes prevent such policy from being translated into practice. This may explain what Willcocks et al. (1982, page 247) call a 'policy gap' or 'mismatch between

the intentions of those who formulate policy and the day-to-day experiences of the residential consumer." Lip service is paid to concepts such as independence and choice which are in effect redefined in order to render them compatible with the pervasive attitudinal construct, which staff adopt to meet the needs of their own 'defensive dynamic.' It is suggested that this is the explanation underlying Booth's contention that (1982), "That over 20 years of research-based criticism has done little to change important aspects of institutions." It is also perhaps what lies at the heart of the delightful but tragic 'advertisement' reproduced below (Rodwell 1982).

BLANKSHIRE COUNTY COUNCIL

Social Services Department

ASSISTANT HEAD OF HOME

£7416 - £8535

The appointment will provide a broad experience in the management of elderly persons. Applicants should have considerable experience in supervising institutional routines. They will be expected to place an emphasis on keeping the Home clean and ensuring that the residents are present at every meal. Preference will be given to those who have been trained to talk about dignity and choice without becoming disturbed by the passive and powerless lives of the residents.

Application Forms from Personnel Section.

The action research undertaken in the home, insofar as it was successful, was so, in the writer's view, because unlike 'research-based criticism' it did begin to address some of

the real issues of staff values and attitudes. There were enough EG attitudes within the group to facilitate some change in the direction of more resident oriented practices. However, the same factors also led to its success having limits: the LTWP construct was too strong to allow much freedom of choice to devolve from staff to residents. Lip service was paid to notions of independence and choice but often these concepts were redefined to make them compatible with LTWP, and terms like 'gentle force' were coined to cover up the power differential that continued to exist between staff and residents and the pervasive LTWP attitude. Interestingly the change in score in the Analysis of Daily Practices Schedule (Evans et al. 1981) was lowest in the resident autonomy section and much higher in the sections on resident care and organisational practices (see appendix 2).

A policy advocating resident-oriented practices is not sufficient to ensure that it is put into operation, although it may well be necessary. Most commentators agree that the factors which result in a residential environment being satisfactory are 'multi-dimensional' (Thomas 1981). These factors could be identified as:

* A policy advocating resident oriented regimes
* Practices and procedures within the home which reflect that policy. For example a key worker system and choice of mealtimes and menus.

* An officer in charge committed to that policy and with the knowledge and skills to translate it into practice and to motivate staff; and a group of staff who are committed to the policy and who do not see residents as less than whole; who can allow people to retain personal autonomy even if they are physically dependent. Staff in other words who do not see themselves as knowing best but who see their role as enabling people to live as they choose. Or as Willcocks et al. (1982) put it, "staff must re-interpret their function and adjust from the role of care provider to facilitator".
* A physical design which enhances the likelihood of resident oriented practices, for example both group homes and homes based on the bed-sitting room principle attempt to build in greater privacy and choice. In such establishments the physical design challenges old routinised ways of caring and thinking.

Research suggests that while few of these factors may in themselves be sufficient to ensure resident oriented homes, each may be necessary or at least very desirable. For example Thomas (1981) concluded that physical design enhanced the likelihood of resident oriented practices but that it was not in itself sufficient, if for instance the officer in charge was

not committed to such provision. Many people confirm the importance of the officer in charge: Evans et al. (1981) describe the importance of both ideological commitment to resident oriented regimes and also the knowledge and skill to create such an environment. Dartington, Miller and Gwynne's work (1981) on the LTWP attitudinal construct shows the crucial importance of attitudes towards residents for both the officer in charge and the staff, if more than lip service is to be paid to resident oriented values. This in turn is enhanced if the policy emanating from the local authority encourages such practices and supports staff in taking the risks which inevitably result from giving clients self determination (see Thomas 1981, page 133).

In the research home a resident oriented policy did exist at departmental level, in that the social services department has policy documents for its new homes (see Appendix 15 for an example) which clearly show commitment to resident autonomy. However such documents were not formulated for older homes such as the one in which the research was carried out, although staff were aware of official desire to move away from block institutionalised care.

The practices and procedures in the home at the start of the research period did not, in the main, reflect the resident-oriented policy, but quite significant improvements were made

in this area as a result of the research group (see Chapter 3.7) for example the development of the key worker system and the change in early morning practices.

The officer in charge was committed to a move towards more resident oriented practices, but even she did not come out against the use of 'gentle force'; in some instances it seemed as if her previous nurse training made it difficult for her to let residents take risks. Nonetheless she was in favour of the extension of residents' rights to choose in relation to for example when to get up and what to eat,

The staff, many but not all of whom had been in the home for some years, were concerned to do their job well. They were, mostly, prepared to change, but such change was ultimately limited by the LTWP attitudinal construct described above which determined the way they saw their role in relation to residents:- looking after, doing to, and taking care of them. Essentially it was a controlling role with a conviction that they, the staff, did know what was best.

Finally the home, in which the research took place, was physically not conducive to resident oriented practices. Lounges in the main were large, a significant proportion of the bedrooms were double rooms, chairs were arranged around the walls, the bedrooms were rather small to personalise and altogether the

physical environment tended to encourage block treatment rather than individual care.

It can be seen, then, that at the start of the research project the home was characterised by a policy, albeit not well articulated at establishment level, which was in favour of resident oriented practices. it also had an officer in charge committed at least part way to giving clients self determination. On the other hand it had a physical structure and many practices which militated against resident orientation and a staff group who in the main believed they knew best.

This state of affairs was affected by the intervention, in the form of the work with the staff group, in two main ways. Firstly the practices and procedures did become more resident oriented, and secondly staff values and attitudes were explored and became more resident oriented within the limits of the pervasive LTWP attitudinal construct. Not surprisingly, given its limited nature, the research did not manage to overcome all the barriers,but it did succeed in moving some way towards a more resident-oriented regime.

As stated earlier Thomas (1981) and many others suggest that the determinants of a satisfactory institutional environment are multi-dimensional. Policies, procedures and physical structures are seen to be beneficial in creating such resident

oriented environments but not in themselves sufficient. Many writers stress the crucial importance of the officer in charge, both in terms of commitment and skills, in determining the regime in the home. It is the researcher's contention that crucial to this commitment of the head of home and her staff is the reformulation of worker/resident roles; that the LTWP construct so often implicit in the term 'resident' needs to be addressed honestly and an attempt made to redistribute the power to control daily life away from the staff and towards residents.

In relation to current practices Willcocks et al. (1982, page 295) maintain that at present "we can offer no evidence to support a view that residents either individually or by their impact as a residential grouping can directly shape or control the physical environment in accordance with their needs." If no such control is provided they argue then what is being offered is "residential care, not residential living."

Dartington et al. (1981) maintain that if such movement towards resident-oriented practices is to take place it is necessary for staff to accept residents' needs for personal autonomy and physical dependence. This requires the role of worker to be re-negotiated away from doing things to people towards helping people live the life they want to lead. In order to do this it would seem that staff would need to find sufficient self-esteem and job satisfaction from enabling rather than doing for the 'defensive dynamic' underlying the LTWP construct not

to come into play. Experimental projects set up to translate the RN construct into practice show how the emphasis on client independence can lead to staff feeling dependent on clients and resentful of it, despite a commitment to client autonomy. For example Dartington et al. describe a unit in which a young physically impaired woman, revelling in her new-found freedom, wanted help to wash her hair at 3 am. It is easy to see how in such circumstances RN could turn into EG pleas to be reasonable, and how this in turn could deteriorate into "we know best" and LTWP. The RN construct, with its emphasis on independence, as well as denying people's dependency needs also fails to acknowledge that the usual state of affairs is interdependence.

Whilst Dartington et al. (1981, page 133) maintain that the majority of transactions between staff and residents are regulated through one or other of the four attitudinal constructs outlined above, they go on to say, "However there may be a residual category of people - including ourselves - who are dissatisfied with these and seeking another position." Such a position, or fifth attitudinal construct, may, they argue, not yet exist, yet such a redistribution of attitudes is necessary if people with various impairments are to be seen as having autonomy needs as well as dependency needs. It is possible to envisage a change in the boundaries between residents and workers, but such a change would necessitate a painful "re-examination of stereotypes projected onto others."

Whilst this fifth attitudinal construct remains elusive it is perhaps possible to begin to outline some of its characteristics. Firstly, as Dartington et al. argue above, residents would need to be seen as people with both dependency and autonomy needs. Secondly the relationship between staff and residents would need to be seen as one of interdependence, rather than dependence or independence alone, involving a negotiation of respective roles. Thirdly this would require a devolution of the power to control daily life, currently very largely held by the staff, towards the residents. Such empowering clearly bears a close resemblance to the person-centred work advocated by Rogers (1961, 1978 and 1980). "The ... person-centred approach, consistently stressing the capacity and autonomy of the person, her right to choose the directions she will move in her behaviour, and her ultimate responsibility for herself in the therapeutic relationship." (Rogers, 1978, page 21). Such self determination does not deny the person's right to choose dependency or to have dependency needs,neither does it deny her right to give as well as to receive: to be inter-dependent. However it does have political implications in that it involves staff relinquishing considerable power and the locus of control to the resident; empowering her "to be that self one truly is." (Rogers 1961, page 163). This then is the alternative meaning of independence, or the "state of self reliance" as Davies and Knapp (1981) describe it, rather than the enforced physical

'independence' so often encountered in elderly people's homes. Brody (1977) expresses it well when she says that "the road to maximum independence is often paved with supports of various kinds."

Tentatively, then, some of the characteristics of a possible fifth attitudinal construct have been sketched in. They consist of a general empowering of residents; a recognition of their dependency and autonomy needs; and a radical renegotiation of staff/resident roles, recognising the interdependence of each on the other. Underlying this construct is a set of beliefs or assumptions about the nature of people: that human nature is basically trustworthy and that if people live in a facilitative environment they will grow in a way which is both personally and socially constructive. Thus the tenets of humanistic psychology as a theory of practice underpin this attitudinal construct, for which the term Whole Person (WP) is proposed. If such a WP attitudinal construct were to be adopted,it is argued, the probability of a resident-oriented environment being achieved would be greatly enhanced. However the radical re-negotiation of roles that would be necessary for such a change to occur would be more likely if the other factors were also positive.

In other words a resident oriented environment would be more likely to occur when there was a clearly formulated and

accessible policy outlining the commitment to such practices; when the design of the home was consciously guided by the need to encourage resident autonomy; when the officer in charge and other staff were appointed for their commitment to the policy and their being prepared to struggle to renegotiate traditional staff/resident roles; and when practices and procedures were formulated quite consciously to reflect the policy.

However, it is also being proposed that whilst the existence of all these factors together will give the best chance of a resident oriented environment, the most crucial is in relation to the officer in charge and her staff being prepared to renegotiate staff/resident roles and to move away from 'we know best' and the LTWP attitudinal construct, towards a more WP approach.

Many local authorities are currently thinking about these issues and this is reflected in the provision made for elderly people. Homes are being built with resident oriented policies in mind and staff are being appointed with a commitment to new ways of working. Several different models appear to be in favour at the present time: these include homes designed around small group living (see for example Marston and Gupta 1979); homes based on larger individual bedsitting rooms and less communal space (see Willcocks et al. 1982); and very

sheltered housing in which care up to the level provided in an elderly persons' home is given, according to need, to tenants living in sheltered housing provided by the district council.

It is clear from research (see for example Thomas 1981, page 133) that such designs are not in themselves sufficient to result in a resident oriented environment. but insofar as they came into being as a direct result of conscious policy that goes beyond general philosophy and begins to suggest practices and procedures which reflect that policy, and insofar as new senior staff are appointed with such a policy in mind, it is likely that the issue of staff/resident roles will be firmly on the agenda and may well be explored and renegotiated. In other words it is being suggested that the likelihood of this crucial area being addressed and resolved may be both more likely and easier in the context of a new home with new staff and an explicit policy of resident orientation, than it is in a traditional home with existing staff and expectations. Willcocks et al. (1982, page 301) for example maintain that "The residential flatlet as a symbol of, and setting for, resident individuality, should be sufficiently powerful to compel staff towards a re-orientation of practice."

These ideas can be formulated in terms of two hypotheses which can be expressed as follows:-

* In order for a resident oriented environment to be

achieved it is necessary for the senior staff to move away from a LTWP attitudinal construct towards a WP approach to residents. Essentially this would entail a radical renegotiation of the traditional roles of resident and staff and a significant transfer of power over daily life from staff to residents.

* This movement towards a resident-oriented environment is more likely to occur if the following are **also** present:

  An official and explicit resident oriented **policy.**

  Procedures which encourage individuality and self determination, such as a key worker system and choice of menus.

  A physical design which encourages individuality, for example single bedrooms.

Thus it is being suggested that the movement away from the LTWP and toward a WP attitudinal construct on behalf of especially the senior staff is necessary for the achievement of a resident oriented environment, whilst the other factors in addition to this are highly desirable and together make the achievement of such a residential environment much more likely. On their own, however, without a movement away from LTWP, they would not result in a satisfactory residential environment.

In order to test these hypotheses the researcher surveyed all the elderly persons' homes in one local authority, in which the officers in charge had been in post for at least 2 years. The following areas were covered via separate schedules.

1. The attitudinal construct of the officer in charge, particularly in relation to how s/he saw the respective roles of staff and residents.
2. The physical design of the home.
3. The official policy of the home. Policy documents existed in newer homes only and where they existed were clearly in favour of resident oriented practices.
4. Practices and procedures in the home.
5. The administration of the Analysis of Daily Practices Schedule. (Evans et al. 1981) to see whether the four areas above had indeed resulted in a satisfactory residential environment.

The following two chapters examine this survey and the subsequent testing of the two hypotheses in more detail.

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CHAPTER 5

METHODOLOGICAL CONSIDERATIONS

CHAPTER 5

METHODOLOGICAL CONSIDERATIONS REGARDING A SURVEY OF ALL THE ELDERLY PERSONS' HOMES IN ONE LOCAL AUTHORITY

5.1 Methodology

The research task for this stage of the work was to collect data about the physical design, the practices and procedures, the policies and the attitudes of the officers in charge of elderly persons' homes in order to see how these related to the overall regime of the homes in terms of their resident or institutional orientation. The question of how to collect that data was the first to be addressed.

Haralambos (1980, page 492) maintains that any sociological investigation is based ultimately on the researcher's assumptions about the nature of people and society. In his view these assumptions guide the entire research operation including:-

the selection of the subject of investigation

the methods and data obtained

the analysis of data

the interpretation of results

This statement implies a rejection of the positivist view of sociological enquiry being the pursuit of 'social facts' and the striving for 'objectivity', and an acceptance of the importance of values and assumptions. Supporting the views of

Haralambos, Heineman (1981) writes; "The essential point is not that assumptions can or should be avoided, but that they need to be made explicit."

This essential conflict, between the positivist search for 'objective' facts on the one hand and the concern about understanding the social and moral context of behaviour on the other, lies at the root of debates about the nature of sociological enquiry and thus about methodology and the quality of data also. Traditionally sociology attempted to be 'scientific' and 'objective', but even early writers, notably Max Weber (see Gerth and Mills, 1948), stressed the importance of verstehen (understanding) and more recently the phenomenological school of sociology has "once again expressed the claims of a verstehenden sociology in a strident form." (Outhwaite 1975, page 13). For them, the phenomenologists, the essential difference between natural and social phenomena is the latter's possession of consciousness: hence the importance accorded to understanding meaning in any method employed. Gidden (1982) maintains that a resolution to the conflict between hermaneutics, the theory of interpretation, and positivism may be found in his theory of structuration in which neither human action nor social institutions take precedence, but where explanation for social practices is found in the study of the relations between the two.

Whatever one's theoretical position, however, the essential question, according to Haralambos, is how to collect valid data, that is data that correspond to reality. Traditional methods, such as the questionnaire, which provide easily quantifiable data and which appear to be objective, have been criticised in that what is important to ask has already been decided by the researcher: the questionnaire may totally miss asking the crucial questions, since it consists of the interviewer's construction of reality not the interviewee's.

For these reasons researchers such as Cicourel (1976) prefer the method of participant observation. By such methods, it is aruged, the researcher can observe the taken-for-granted assumptions which regulate interaction between people, and which constitute an explanation of their behaviour. This method clearly relies on observation and interpretation, and whilst this means that the researcher is not imposing his or her views in the same way as a questionnaire does, it is still dependent on the validity of the researcher's interpretation of what he or she has observed. Many writers attempt to overcome this problem by quoting long extracts of detailed interaction, but essentially this leaves the reader in the same position as the researcher, having to interpret the meaning. Indeed such are the problems that Haralambos writes (page 503) "At the end of the day many would argue that the problem of validity is insoluble."

Interviews are a further method often employed to elicit data. Highly structured interviews in which the same questions are asked in the same order have the same epistemological strengths and weaknesses as questionnaires: they produce 'objective', quantifiable and reliable data which may or may not be valid. Unstructured interviews, which are often employed to study attitudes and behaviour, do at least permit a rapport to develop between interviewee and interviewer and for at least some of the control of the interview to rest with the interviewee. However, research shows that what people say may "bear little relation to actual behaviour" (Haralambos 1980). In addition the question of how interviewer and interviewee perceive each other may affect the interaction between them. Particularly the values of the researcher may communicate themselves to the interviewee who may, often unconsciously, answer in a way which it is thought would please the interviewer. Data from such unstructured interviews is also notoriously difficult to quantify or compare.

In short there appears no easy solution to the quest for valid and reliable data: all methods have their strengths and weaknesses. In relation to this particular stage of the research, the collection of data relating to physical design, practices and policies appeared relatively straightforward compared with the difficulty involved in ascertaining

people's attitudes, with their cognitive, affective and behavioural components.

It must be apparent from earlier critiques (see Chapter 3.8) of the Evans schedule (Evans et al. 1981) that the author's position includes an uneasiness with the sole use of highly quantified and so-called objective data, and a sympathy with methods which also seek to understand the meaning of situations from the participants' point of view. However in this section of the research inquiry some weighting or quantification was necessary in order to test the hypotheses about the relationships between physical design, practices, policy, attitude and regime. Additionally there was simply insufficient time to observe practices covering the waking day in eighteen homes, and even if this had been possible, the question of interview bias would have remained. Finally the decision was reached to use a variety of methods: structured interviews, critical situation analysis and limited observation in the belief that together they would provide a reasonably valid picture of the physical and social environments in eighteen elderly persons' homes. Kitwood (1980), discussing these methodological issues in relation to studying adolescents' attitudes and values, writes, "There are many practical limitations to this kind of work - one being obtaining willing co-operation. Thus it may be necessary to obtain data by whatever means are feasible and to compensate by

as careful and critical an interpretation as one can make."

Schedules were relatively easily drawn up to ascertain details about physical design, practices and procedures and policies (see appendices 5, 6 and 7). The content of these was informed by current research on design, practices and policies thought to enhance the likelihood of a resident-oriented environment. The scoring was similar to that employed by Evans et al. (1981) in the Analysis of Daily Practices Schedule: namely a score of 1 for an 'institutional' answer and 0 for a 'resident oriented' answer. Because the opportunity to choose a single room seemed so crucial a design feature in the quest for a resident-oriented environment, the lack of such an opportunity was given a score of 2, otherwise all items scored 0 or 1. All three schedules had a maximum score of 11. It was planned to administer all three schedules in a fairly structured interview situation.

Despite certain reservations about the Analysis of Daily Practices Schedule (Evans et al. 1981), it was decided to use this to study the regime in each home. Certainly by its second administration in the original research home it had been fairly successfully employed and was familiar to the researcher.

The attitudinal schedule remained: the most difficult to

construct and in many ways the most crucial in that it was central to the hypotheses formulated. An early decision was made to focus on the officer in charge, rather than attempt to monitor the attitudes of all the staff, largely because research suggests that his or her attitudes will affect the home most significantly, but also because to interview the total numbers of staff involved was beyond the resources of this study.

What was required was a method of finding out what the attitudes of officers in charge were towards residents and in particular how those attitudes regulated in practice the relationships between staff and residents. It was the researcher's view that such data could not be found by asking people what their attitudes were: something more sophisticated was required.

Kelly's work (1955) on repertory grids as a method of ascertaining people's attitudinal constructs seemed a promising possibility. However a brief study of the literature revealed that the method was only held to be valid if both elements and constructs were determined by the interviewee. Since this would not have enabled comparisons to be made easily between the various officers in charge, this line of enquiry was reluctantly abandoned. Kitwood (1980) too considered Kelly's work in his search for a meaningful methodology.

He was attracted to the idea of situation grids, but a pilot study revealed that adolescents did not easily see themselves in terms of bi-polar constructs such as rebel or victim. However what he did find was that "the underlying idea of representing adolescent life by focusing on incidents that either had particular significance or epitomised some of its main features seemed to be meaningful and acceptable." He found that a focus on situations "provided natural access to participants' central concerns." Again he says that the method shows "the uniqueness of each person's outlook and social situation" but "does not set out to elicit the full repertoire of evaluative constructs of any one individual." Thus he abandoned the idea of using grids but kept the use of situations. Kitwood's experience seemed helpful in that it mirrored many of the methodological concerns of the researcher.

Accordingly four separate schedules were drawn up: each in its way aimed at attempting to discover people's attitudes to residents and how they saw and practised the role relationship between them. The intention was to pilot these four schedules, evaluate their effectiveness and decide to use one of them for the main survey.

The first was a fairly traditional attitudinal questionnaire: the respondent was given 44 statements relating to key aspects

of residential life and asked to indicate those statements with which s/he most strongly agreed. The items varied from LTWP statements like "Residents should get up reasonably early: it is good for them", to statements like "Residents should decide how far to participate in activities" (see Appendix 8).

The second attitudinal schedule was a critical incident analysis. The officer in charge was given details of a hypothetical resident, a member of staff and a letter from the resident's daughter complaining of the staff member's rough and rude treatment of her mother. The officer in charge was then asked to outline how s/he would handle such a situation (see Appendix 9). It was thought that asking officers in charge to describe how they would react to a situation which could very easily occur within a home, might well elicit attitudes more accurately than a more conventional approach such as the 44 statements. In particular it was hoped that the responses would indicate not just the attitudes towards staff and residents' roles, but also the way in which such attitudes would regulate relations between them in practice.

The situation was deliberately described in a manner which left the actual course of events in some question: all the officer in charge had to respond to initially were the daughter's perceptions of what had happened to her mother. It was envisaged

that some people would be quick to make assumptions about the accuracy of those perceptions and that others would see the need to check out other people's views of events. Despite such ambiguities the situation was a critical one in that the officer in charge had to respond in some way to the letter and such responses, it was thought, would indicate something of his/her attitudes towards staff and resident roles.

The third schedule contained brief details of three applicants for a hypothetical junior staff vacancy in the home. The officer in charge was asked to choose the person s/he thought most suitable to work in the home and to explain that choice (see Appendix 10).

The final attitudinal schedule asked the officer in charge to give the characteristics s/he would expect to find in a good and bad resident, member of staff and officer in charge. This was called the character profile schedule (see Appendix 11).

The decision of how to score and analyse these attitudinal schedules was left until after the pilot survey was completed when the usefulness of each schedule could be evaluated together with the responses to it. In addition, at this stage the Social Services Department staff were shown the schedules and gave permission for the officers in charge to be approached once the pilot survey was complete.

5.2 The Pilot survey

Two neighbouring Social Services Departments were approached and permission was given for a number of officers in charge to be approached and asked if they would participate in the pilot survey. A letter was sent to each outlining the research in brief and asking the officer in charge if s/he would be willing to participate. It also said that the researcher would 'phone in a few days to find out if the person would be prepared to take part and if so to arrange a mutually convenient time to visit. This method of a letter plus a follow up 'phone call proved very satisfactory and everyone approached agreed to take part. Finally five people were interviewed, although that is perhaps too formal a word for the helpful and participative experiences the visits proved to be. Each visit took between one and a half and two and a half hours, depending largely on the time at the disposal of the officer in charge and on his/her interest in and desire to talk about the subject of the research.

The schedules relating to the physical design, practices and policies were administered first and few problems were encountered with them. One or two minor changes to the wording and content were made. For example the practices schedule asked if there was a resident's committee. Some homes had residents' meetings instead in order to involve everyone, and so residents' meetings were added to question 5 of that

schedule. The researcher also discovered that whilst few homes offered a choice of menu (see practices and procedures schedule appendix 6) many more offered an alternative, such as cheese, if people did not like the main dish. It was decided not to count this alternative as a choice, but the researcher had to remember to ensure that people understood what choice meant in the context of the survey.

The officers in charge were asked to complete all four attitudinal schedules and were later asked which one had most closely approached their real feelings about and attitudes towards their work. The answers to this question, however, proved of little help in choosing one schedule to use in the main survey since each one was liked most by at least one of the people interviewed.

A decision had to be made about whether to use a tape recorder for the interviews or to make notes. It was the researcher's view that people would talk less freely and informally into a tape recorder and so notes were decided upon. This was explained at the beginning of the interview and several people expressed relief that the proceedings were not to be taped. Note taking proved relatively easy and quite complex ideas could be noted fairly quickly and unobtrusively. The questions on the first three schedules, relating to physical design, practices and procedures and policy, were asked

verbally and the responses, usually but not always yes or no, noted down. The attitudinal schedules were given one at a time to the officers in charge to read and again their responses, this time more complex, were noted.

Since the researcher was already familiar with the use of the Analysis of Daily Practices Schedule (Evans et al. 1981) a decision was made not to pilot it. In addition a decision to have included it together with the four attitudinal schedules and the other three would have made the visits unnecessarily long.

The letter had asked the officers in charge if the visit could conclude with a brief tour of 'the public parts of the building' particularly if the researcher was unfamiliar with the home. This proved an enlightening experience: all took the researcher into residents' rooms and it was fascinating to observe whether they knocked and whether they then asked the resident if they could show a visitor round, told her, or, on on occasion, ignored her altogether. In the main people's actual behaviour in relation to residents corresponded quite closely with their avowed attitudes, but the final visit resulted in consistently enlightened responses to the schedule questions and yet when taken around the home the researcher was taken into people's bedrooms without the door being knocked and without being introduced to residents. In addition residents

were talked about in their presence. This experience highlighted the methodological problems outlined above in relation to ascertaining people's attitudes. The researcher is convinced that the person was unaware of any discrepancy between what she said and what she did and yet the discrepancy was only too apparent to an observer. It is known that attitudes have a behavioural component which may be different from their cognitive and affective components and this appeared to be the case with this officer in charge. Whichever attitudinal schedule was chosen it could be said to lack a behavioural component, although the critical situation analysis did involve asking people how they would behave, which may or may not be the same as actual behaviour.

On reflection, it seemed that the requested tour at the end of the visit of 'public areas' of the home and the associated conversations could provide a valuable opportunity to study the elusive behavioural component of people's attitudes.

In order to analyse people's behaviour comparatively it was necessary to identify certain features of their behaviour which could indicate their attitudes towards residents. From the experience of the visits which constituted the pilot survey the following seemed appropriate:

- was the visitor introduced to staff and residents met on the tour of the home?

- did the officer in charge knock on the door of residents' rooms before entering?
- did s/he ask if s/he could bring a visitor in?
- did s/he listen and respond to residents who talked to her/him on the way round the home?
- did s/he treat residents as equals and adults?

These appeared to be relatively simple but telling features which the researcher could easily remember and note down immediately after leaving the home and which would go some way towards overcoming the inherent weakness of the other attitudinal schedules in asking people to say what they thought and report on what they thought they would do in certain situations.

Of the four attitudinal schedules, one, the 44 statements , was easily discarded. Not one of the five participants in the pilot survey choose a statement which reflected a LTWP attitude, even though their responses to some of the other schedules and sometimes their actions suggested they did hold such attitudes. The experience of the others was good, particularly the critical situation analysis: it provided certain clearly discernible patterns of response which suggested people's attitudes, and it confirmed Kitwood's view (1980) that such an approach provides both a framework and a freedom for the individual to respond.

The responses to the job application schedule were fascinating, but perhaps left more room for interpretation by the researcher in the analysis. For that reason it was rejected.

The final attitudinal schedule, the character profiles, gave some extremely useful results: responses to the question "What is a bad resident?" for example varied from, "I don't accept that construct: there are no bad residents." to, "One who does not fit into the life in the home."

Finally it was decided to keep both the character profiles and the critical situation analysis,as well as using the analysis of the tour around the home. This was a much more complex procedure than had been envisaged originally, but given the complexity of attitudes and the difficulty in identifying them it seemed a reasonable decision to have several different methods.

The question remained of how to 'score' the attitudinal schedules. The other three had a maximum 'institutional' score of 11, and in order to test the hypotheses comparisons had to be made with these three scores and the score on the Analysis of Daily Practices Schedule.

An examination of the responses to the critical situation analysis revealed 11 common responses which could relatively

easily be given a score of 0 (demonstrating a person-centred attitude) or 1 (demonstrating a LTWP approach). These were as follows:

1. Write to the daughter, acknowledging receipt of the letter and promising to investigate. (score 0).
2. Acknowledge that staff hurting residents is wrong. (score 0).
3. Acknowledge that staff being rude and 'too busy' to take the resident to the garden is wrong. (score 0).
4. Openly acknowledge receipt of the letter to the member of staff and resident concerned. (score 0).
5. Ask the staff member's point of view in a non-judgemental way. (socre 0).
6. Ask the resident's pont of view in a non-judgemental way. (score 0).
7. Consider the training needs of the member of staff (aids, lifting, policy about time to listen to residents). (score 0).
8. Think about the possibility of changing the key worker if the member of staff and the resident do not get on. (score 0).
9. Find out how the member of staff does work with the resident, by observation, bathing with her, and asking other senior members of staff. (score 0).
10. Blame the resident for making mischief.(score 1).
11. Blame the daughter for making it all up because she

is feeling guilty that her mother is in care.
(score 1).

The presence of any of these items would receive the score indicated, if they were absent, the other score would be given.

The character profiles consisted of six categories: good and bad resident, good and bad member of staff and good and bad officer in charge. Each category was allocated a score of 0, 1 or 2 (0 being person-centred, 2 institutional) giving a maximum of 12. A score of 2 would be given to an answer such as, "A bad resident is one who doesn't fit into the home," whereas a response of "good residents are ones who decide for themselves how to live their lives," would receive a score of 0.

To the five categories outlined above in the tour analysis a sixth was added (see Appendix 12) which required the researcher to judge how much the residents controlled their daily lives (score 0) and how much the officer in charge was in control (score 2). This was because in almost every instance a strong impression of who had control was apparent and this seemed crucial in any analysis of attitude towards residents. Each of the other five categories relating to the tour were also scored 0, 1 or 2, giving a maximum total of 12.

It was proposed to add these three attitudinal scores together and arrive at an average score by dividing the total by three. Since two of the three had a maximum score of 12 and the other of 11, it was envisaged that the scores might have to be converted into percentages to make them comparable for the purposes of statistical analysis.

Informal discussions with the officers in charge who participated in the pilot survey frequently included some unsolicited comments about training and its impact, or not, on a person's ability to bring about institutional change. This seemed to be an interesting idea to pursue and a decision was made to gather information about the professional qualifications held by the officers in charge of the survey homes, to see if any patterns emerged in relation to qualification and the quality of the residential environment.

With such a small number of homes in the pilot survey it would be unwise to generalise from the results obtained, particularly since the tour analysis was not decided upon until after the completion of the pilot survey and therefore data for it were not systematically collected. The scores for the physical design schedule varied from 2 to 7, for the practices and procedures schedule from 3 to 7, for the policy schedule from 4 to 9 and for the attitude schedules from 3 to 6. There appeared to be a relationship between the scores of three of the schedules: physical design, attitude and practices

and procedures.

The pilot survey was thus complete and it had fulfilled its purpose in that the physical design, practices and procedures and policy schedules had proven their worth with minor amendments ; and the experience of the visits had enabled decisions to be made about the attitudinal schedules.

The experience was a fascinating one for the researcher, and many of the officers in charge also said that they found it useful to have the opportunity to talk and think about their practice in some detail. Certainly the interviews were not highly structured or tightly controlled by the researcher, although there was a necessary element of both present. In addition however there was dialogue, humour, openness and hospitality and the researcher was content that the chosen methods were acceptable to both herself and the officers in charge. Like Kitwood (1980) what was required for this research was to develop a methodology which "would not treat the people who participated as objects who were labelled or diminished and if possible to leave them with increased insight and personal autonomy."

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CHAPTER 6

EIGHTEEN ELDERLY PERSONS' HOMES:

THE SURVEY FINDINGS

CHAPTER 6

EIGHTEEN ELDERLY PERSONS' HOMES: THE SURVEY FINDINGS

6.1 INTRODUCTION

Having piloted the schedules and made final decisions about which to use, the main survey was undertaken. A survey has been defined as "an inquiry which involves the collection of systematic data across a sample of cases, and the statistical analysis of the results." (Marsh 1982, page 9). Broadly this survey conforms to this definition although the results are analysed qualitatively as well as quantitatively.

In the county there were 24 elderly persons' homes (excluding the one which makes provision for elderly people with mental infirmities). Since one of the main hypotheses to be tested by the survey related to the extent to which the attitudes of the officer in charge were correlated with the regime in the home, it was felt that it would be unwise to interview heads who had not been in post for sufficient time to put their ideas into practice. After consultation it was decided to fix this period of time at 2 years. This ruled out five homes in which the officer in charge had been in post for less than this period of time. Sadly of these five one was the original research home and another the home to which the officer in charge had moved. This left nineteen homes, one of which the researcher was asked not to approach by the

Social Services Department.

Letters were sent to the officers in charge of the remaining eighteen homes (see Appendix 13) and, keeping to the pattern of the pilot survey, were followed up by a 'phone call a few days later. Again everyone agreed to participate and dates to visit were negotiated over a period of three weeks. The lack of refusals to respond was gratifying, particularly in the light of general response rates. Hoinville and Jowell (1978) for example maintain that, "Survey response rates above 85% are rare." (page 6). A deliberate decision was made to introduce the researcher in the letter as a CSS tutor as well as a researcher. This was partly because this was the context in which most of the officers in charge would already know her or know of her, and partly because it was thought this would be more meaningful and possibly credible than "research for a higher degree" on its own.

The visits lasted between one and a half and almost three hours and with one exception the questions were answered by the officer in charge, although on a few occasions the deputy was also present for at least some of the time. The exception was where the officer in charge was present but feeling unwell and so most of the questions were answered by his deputy who was also his spouse and an ex student of the researcher. It became apparent that the two were answering significantly

differently with the deputy being far more aware of the implications behind certain questions. Thus the schedule scores for this home (number 7) probably reflect far more of the deputy's views than those of the officer in charge.

In most instances the officer in charge also accompanied the researcher on the tour of the home, but on four occasions, in addition to home number 7 above, this was not done and another senior member of staff, often the deputy, did this. In each case the reason was other demands on the time of the officer in charge. Thus in these homes (numbers 5, 10, 12 and 14) the attitude schedule score is more a composite of senior staff's attitudes than simply those of the officer in charge.

In addition one officer in charge, of home number 9, had decided that the researcher would receive a truer picture of the home if she was accompanied by residents rather than staff and subsequently when the researcher arrived two residents had volunteered to take her round the home. In itself this suggestion by the officer in charge demonstrated something of her attitudes and the tour itself was fascinating, amply demonstrating that residents did have access to all areas of the home, and that the relationship between residents and staff was characterised by equality and a lack of infantilisation.

In similar vein, another officer in charge of home number 15, had arranged for the researcher to have coffee with all the domestic and care staff on duty in order to ask them their views of the home. Such thoughtfulness was much appreciated.

Of the eighteen officers in charge, nine were already known to the researcher, five extremely well, being ex or current students. In addition four ex or current students were deputies in the homes and were present for at least some of the visit.

The eighteen homes consisted of two converted from large old houses (numbers 10 and 14); four which were new purpose built homes based on the bed sitting room concept (numbers 8, 9, 13 and 18); one which was a prototype for the latter (number 17), and the rest which were older purpose built homes with a combination of single and double rooms.

The format for the interviews was the same for all: after introductions and greetings the purpose of the research was explained again, together with a brief description of what the interview would entail. These explanations were followed by asking verbally the questions on the physical design schedule, followed by the practices and procedures and the policy schedules. Next the officer in charge was asked to respond to the critical situation analysis and the character profiles. Finally the Analysis of Daily Practices Schedule

(Evans et al. 1981) was introduced as a published instrument designed to discover how institutional or resident centred a home was. After the Evans schedule was completed the researcher was taken on a tour of the home. Immediately after leaving the home additional notes were made of impressions of the home and a description of the tour using the criteria outlined above in the section on the pilot survey (see Chapter 5.2).

6.2 FOUR HOMES

Whilst the methodology for the survey had been designed so that eventually the responses to each schedule could be reduced to a single score, it was apparent that to present the results solely in such a manner would miss entirely the rich qualitative nature of the data. A decision was made therefore to present and analyse the material both qualitatively and quantitatively.

Having visited the eighteen homes and spent a considerable amount of time in each, the overall impression was one of variety and of the complex interaction of the factors under investigation: physical design, attitudes, policy and practices. In some homes all four features were positive, but in many more the relationship between the factors was much less clear. It was the way in which these factors inter-related, and how they affected the overall quality of the residential

environment which was of particular interest.

Accordingly, four homes have been selected which illustrate some of the different patterns which emerged. They are homes numbered 4, 9, 13 and 15. (Table 6. 5 below, page 294 gives the schedule scores of all the homes.) Home number 4, which may be referred to as The Beeches, was an older purpose-built home with a similar physical design to many of the other homes, yet it received the most institutional score, of 32, on the Evans schedule (see Appendix 1) of all the survey homes. Home number 9, The Elms, which co-incidentally was geographically situated within a few miles of The Beeches, was a new purpose-built home built on the bed-sit principle. It received the lowest, that is most resident-oriented score, on the Evans Analysis of Daily Practices Schedule (Evans et al. 1981). The Poplars, home number 13, was also a new bed-sit home, but it scored the highest of all such homes on the Evans schedule, with a score of 14 compared to the The Elms' score of 9. Finally, Hawthorne House, home number 15, was an older purpose-built home, very similar in age and physical provision to The Beeches, and interestingly identical in physical design terms to the original research home. It received the most resident-oriented score of all the non-bed-sit homes, scoring 15, just one point higher than The Poplars, a home with many physical advantages over Hawthorne House.

The Beeches was the first of the four selected homes to be visited. It was built as a five unit home to accommodate 50 elderly persons yet the use of the units was not harnessed in any way to foster group living. The only evidence which was seen of the home operating as a unit home was the provision of a servery in each unit at which tea could be made. Even here, however, it was acknowledged that supplies of tea were not always available although they should have been. The officer in charge estimated that 80% of the time tea probably was available.

The overall impression of the home was depressing: there was a strong smell of urine in several areas of the home, and both staff and residents seemed depressed and defeated. Physically (see Appendix 5 for the schedule on physical design) the home was quite typical of many purpose-built homes, indeed it ranked joint sixth best with Hawthorne House on the physical design schedule (see Table 6.5, page 294 below). Thereafter, however, any similarity between the two homes finished. Apart from having few single bedrooms, the main physical disadvantages of The Beeches were the small size of the rooms precluding residents from bringing in large pieces of furniture and the less than generous width of doors.

In terms of practices and procedures in the home (see Appendix 6 for schedule) the officer in charge readily offered the

information that getting infirm residents up could be started as early as 4.30 am. by the night staff, although he also said that they should not start in his view before 6.15, even for the most infirm. This was an extreme example of the way in which already limited choice is further reduced for infirm residents. Breakfast was at 8 am. and the need to get everyone up and in the dining room by this time, together with the number of people who needed help with dressing, determined the early start. People who were sick or very old and infirm might be 'allowed' breakfast in bed if the staff thought that was justifiable.

There was no key worker system in this home and few staff meetings were held apart from those for senior staff. Occasionally, if for example a fete was to be held, a care staff meeting would be called. The officer in charge hoped there was good informal communication within the home, thus obviating the necessity for regular staff meetings.

In relation to admission procedures, emphasis was given more to prospective residents visiting The Beeches than to visiting people in their own homes. This was because the officer in charge thought that the condition of residents' homes was more or less immaterial to their future at The Beeches.

There was no policy document at The Beeches, although the

officer in charge said he would be prepared to have one if he was encouraged to by 'county hall'. He was of the opinion that in addition to 'descriptive and theoretical stuff' emphasis should be given in such a document to the responsibilities of families of residents. These in his view needed stressing in terms of the expectations the home had of both residents and their relatives. He saw relatives as needing to take more responsibility in terms of their 'practical obligations'. These were seen to be visiting, taking residents out, overseeing their clothes and so on. Such responsibilities or obligations were seen as the often unexpressed other side of the notion of freedom.

The officer in charge of this home received the highest, that is most institutional, score of the eighteen people interviewed on the attitudinal schedules (see Table 6.3, page 285 for scores and Appendices 9, 11 and 12 for schedules). Interestingly, the score of the tour analysis was particularly high, although on all three schedules he scored higher than anyone else. Throughout the replies to the critical situation analysis and the character profiles there was evidence of the importance given to control by the senior staff of both other staff and residents. For example in the critical situation analysis the officer in charge stated that if he discovered that the member of staff and the resident were incompatible he would talk to them both and say, "You will HAVE TO BE friends."

Neither staff nor resident would have much say in the matter. Similarly in the character profiles a 'good resident' was seen as one who wished to get the most from the home and who wanted to come in. Interestingly mention was made of the lack of importance, in this context, of physical frailty, providing the approach to the home was 'right'. A 'bad resident' was seen as one who did not fit in with the way of life in the home and who 'carps all the time'. The issue of control was also apparent in answer to question 2c2 on the Evans schedule. No fewer than 30 residents had their monies controlled, a far higher number than in most other homes.

However it was on the tour of the home that the attitudes of the officer in charge became most apparent. He either did not knock or barely knocked at doors before entering; did not introduce the visitor in any way in the lounges visited; and told residents in bedrooms that he was taking a visitor round, rather than asking them if he could. Two conversations are remembered particularly vividly. One was of the officer in charge asking a resident how she was, then turning to the researcher and saying, in the same voice, before walking out of the room, "We won't stay long or she'll tell us for a long time." The other incident related to a man who shared a double bedroom. The researcher was told on being shown the empty room that one of the occupants was

"what we used to call MD." Later, in a lounge the same person was pointed out quite openly with the comment, "He's the one I was telling you about."

Bedrooms in this home were in the main depressing, bare, even grim. Even the ones that had been recently redecorated had been done without any consultation with the residents, and even after redecoration managed to remain institutional-looking.

It was at The Beeches that the Less Than Whole Person (LTWP) attitudinal construct was most apparent in practice. Emphasis was given to "we know best" throughout. Significantly this approach was extended not simply to residents but to other staff and relatives too: they all needed to be told how to behave. Scant regard was given, as a consequence of this attitude, to people's privacy or right to be treated with dignity and people had little control over their daily lives. Overall the visit was depressing and at times acutely embarrassing.

In relation to the factors under consideration, it seemed likely that at The Beeches the over-riding LTWP attitude was the main determinant of the institutional score on the Evans schedule. The quality of the residential environment was much lower than one might expect, given the albeit less than perfect physical environment. Although there was no policy document

relating to the home, the policy of the officer in charge was clearly that residents and staff had to fit into the routines of the home.

The experience of the visit to home number 9, The Elms, just down the road, could not have been a greater contrast. In almost every way The Elms came near to being an ideal home. It achieved the least institutional score on all the schedules with the exception of the attitude score where it came a close second to home number 18. Physically it was spacious and well planned. Single bed-sits were provided for residents and the home was situated within easy reach of neighbourhood shops.

The practices and procedures within the home had been clearly thought out in terms of their reflecting an articulately expressed resident oriented philosophy. Key workers took on responsibility for the total care of the residents allocated to them; breakfast was staggered from 8.30 - 11.00 am.in the dining room and was also available in residents' own rooms; residents had keys to their rooms; domestics negotiated with residents about the cleaning of the rooms; and regular staff meetings were held.

The use of keys at The Elms was particularly interesting. They were seen by the officer in charge as serving many functions. Firstly of course they gave the residents privacy and a degree

of control over their own territory. However their use also solved at a stroke the problem of confused people wandering into others' rooms or beds and possibly taking their belongings. In addition they encouraged domestics to negotiate the cleaning of rooms with residents, since they had to find the resident to obtain the key to the room. Safety was maintained by the senior staff on duty having master keys.

The policy document relating to The Elms was excellent and is included as Appendix 15.

In response to the critical situation analysis (see Appendix 9) the officer in charge of The Elms showed an open mind and a lack of easy answers: she would talk openly to both the resident and the member of staff about the letter, with the emphasis on discovering what had happened and understanding why. Whilst firmly of the opinion that rough handling was a serious matter, she thought there may be some explanation for it. Changing the key worker was an option she might pursue, in consultation with the resident and staff concerned and other staff, if the problem seemed to centre around a personality clash. The daughter was seen as quite right to have expressed her views and the officer in charge would do all she could to reassure her that her mother was being protected.

The constructs of good and bad residents were roundly rejected

by this officer in charge (see character profile, Appendix 11). "People are people," she said firmly. A good member of staff was seen as someone who understood the needs of elderly people and who had a sense of humour. A good officer in charge was described as one who could stand back and critically evaluate the home; someone who could let go of the home and not see it as her own personal property; and someone with sensitivity to the needs of residents and staff. To that end she did not expect residents or staff to be perfect: she acknowledged that the work was demanding and sometimes wearing. If a key worker just could not face bathing a very trying resident, she would be encouraged to say so and someone else would volunteer to do it that time. Neither was the officer in charge afraid to say that she had had enough on occasion, and it was apparent that staff supported each other at such times.

The tour of The Elms was unique in the experience of the survey in that the officer in charge thought that a more accurate view of the home would be obtained if residents took the researcher around. Two residents had already volunteered to do so and it was a novel and illuminating experience to be introduced to staff by residents. The relative equality of the relationship between residents and staff was clearly demonstrated on this tour, as was the freedom of access residents had to all parts of the home, including the kitchen and laundry.

Additionally there was a very real sense of being invited into people's private rooms to which they had keys. One of the residents was a keen gardener and, although physically frail, had taken over some of the flower beds in the garden. These were a source of great pride to her, as were the many cuttings in her room, and the reseracher left the home with a cutting and a small nosegay of flowers given to her by this resident, together with many good gardening tips. Clearly not all residents in the home were as active, but a fair number were involved in interactive games and activities, such as cards, dominoes and jigsaws, at the time of the visit, just before lunch.

Clearly this was a home with advantages over many of the others. Physically it was delightful, the only criticism being that as it was only two years old the rooms had not been redecorated and were thus all painted in the same pale colour. The official policy document was sound also and was translated into practice procedures, but in addition the home was run by a woman who regarded residents as people first and foremost. Her respect for them was very apparent and she saw her task as running the home in such a way as to maximise the control residents could maintain over their daily lives. It was in The Elms that one could best see glimpses of what the Whole Person (WP) attitudinal construct might look like in practice (see Chapter 4). Here dependency needs were not denied, but neither

was dependence in one or two areas seen as a reason for treating the whole person as less than whole: autonomy and self determination were maintained as far as possible. Staff, too, were seen as whole people with strengths and weaknesses. The notion of inter-dependence was very apparent with people helping each other, both between staff and between staff and residents. Residents were not seen solely as receivers, but as having something to give as well, as in the case of the flower beds. Here, then, the factors of design, policy, practices and attitudes were all largely advantageous and indeed they combined to result in the most resident-oriented institutional environment found in the county. The contrast with The Beeches could not have been greater.

The Poplars, home number 13, on the other hand, shared many physical advantages with The Elms. It was perhaps an even more attractive building overall, with the same individual bed-sitting rooms for residents and an excellent and very similar policy document. In many ways too these advantages were reflected in the quality of the residential environment, which appeared lively and with many activities taking place. The score on the Evans schedule was relatively low, however the score ranked fifth out of the eighteen homes surveyed, and was the highest, that is the most institutional, score of the bed-sit homes.

At The Poplars the various factors being explored did not complement each other in the same way as at The Elms: the interaction between them appeared more complex. Neither were the attitudes expressed clearly from a Less Than Whole Person (LTWP) construct. Indeed great store was placed on privacy and independence; all the 'right' things. The policy document was seen as excellent and some comment was made about using it as a bible. In a way this remark provided the clue: commitment was given to many of the tenets of resident-oriented practice, but these seemed in some cases to be imposed on people irrespective of their needs or wishes. The tenets had been accepted but the underlying Whole Person attitude was absent. Rather, privacy and independence were imposed on people because it was good for them: back to 'we know best' again, albeit a relatively progressive 'we know best'. Two incidents in particular served to reinforce this analysis. The first related to two women admitted to the home from a local mental handicap hospital. They were referred to as 'sub-normals' by the officer in charge: not Whole Person terminology. They were great friends and had for years never slept apart. The usual practice in bed-sit homes when married couples, or anyone else for that matter, wish to share a room is for the pair to be offered two adjacent rooms: one to be used as a double or twin bedroom and the other as a private sitting room. However at The Poplars these two women were given two separate rooms, 'because privacy is good for people'. One

of the women in particular found sleeping alone a frightening experience and had to have the door open and the light on for some considerable period of time. Eventually, however, "she adapted." The researcher asked what would have happened had she not settled, fully expecting that the two would have been offered a twin bedroom as outlined above. However the officer in charge said this would not have been possible, again because "privacy is good for people."

The second incident took place at lunch, which the officer in charge was very keen that the researcher should observe. Indeed she was taken rather ceremoniously into the dining room and publicly introduced as a CSS tutor who wanted to see the way lunch was organised in the home. Then she was given a seat at an empty table and left alone 'to observe'. This was a rather embarrassing situation to be put into, but an equally difficult one from which to extricate oneself. One of the features of lunch, of which the officer in charge was obviously proud, was the way in which 'independence' was fostered. This was achieved by every resident being encouraged (although 'gentle force', the term coined in the original research home, might have been a more accurate term) to return something to the servery after they had eaten. What was returned varied from all the table ware used by the most physically able, to anything as small as a spoon by the physically frail. One man, for example, with many physical

impairments, struggled for some minutes to bring a saucer in the bag attached to his zimmer frame. The officer in charge offered voluble encouragement to him and others and gave much praise when they had completed their task. This appeared to be an example of independence being interpreted in largely physical terms, rather than being seen to be about making decisions about how to live one's life, and again to all intents and purposes this 'independence' was imposed on people. On the other hand it was apparent that some old people enjoyed returning something, and felt some pride in their achievement; others may have preferred to use their limited physical abilities in activities of their own choice.

The prevailing attitudes were thus complex: lip-service, and more, was paid to resident-oriented practices, but only or largely if residents chose to exercise their choice to be independent or private in the way in which the officer in charge thought they should. "I like residents with spirit," said the officer in charge, and although she thought the concept of a bad residents was ridiculous, she went on to define such a person as, "One who doesn't want to be here." Thus there were elements of the 'we know best' approach usually associated with the Less Than Whole Person construct present. However there was also a denial of some dependency needs which is often an indication of a Really Normal approach. For example residents had to keep going physically by taking back something,

however small, to the servery after a meal. They could not choose not to make the sometimes considerable physical effort. Equally the resident from the mental handicap hospital had to learn to be independent of her friend, because it was good for her.

Certainly the Whole Person construct was not very apparent either in the way in which staff were told to do things or in relations between staff and residents.

Thus it is being suggested that at The Poplars, whilst the physical design, the policy document and the commitment of the senior staff to many of the practices extolled in that document resulted in a residential environment which in many ways appeared resident-oriented, in some important aspects this was limited by the lack of a Whole Person attitude underpinning the whole enterprise. The assertion is that this was the reason for the relatively high score on the Evans schedule compared with the other bed-sit homes. Again, as in the original research home, concepts such as independence and choice, usually associated with resident-oriented practices, were redefined in subtle ways to make them compatible with an underlying notion of 'we know best'. In the home in which the action research was undertaken it included getting up early and doing what the staff said; at The Poplars it included being independent by choosing to get up late or have an untidy

but personalised bedroom. In both homes however physical 'independence' was seen as very important and this was encouraged, or, depending on one's point of view, gently forced, irrespective of people's wishes.

The fourth selected home, number 15. Hawthorne House, was very different from The Poplars in almost every respect. Physically it was identical to the original research home and home number 7, but it had many similarities with all of the older purpose-built homes including The Beeches. However according to the score on the Evans schedule (The Analysis of Daily Practices schedule, see Appendix 1) it achieved a more resident oriented environment than any of them, scoring only one point higher, out of 77, than The Poplars which enjoyed many physical advantages. There was no official policy document for Hawthorne House, although it was quite obvious that the absence of such a document did not mean the absence of a resident oriented policy. Many such practices and procedures had been introduced, for example the option of breakfast in bed which meant that residents could get up when they wished, and a well-developed key worker sytem. However of all the factors under consideration it was in relation to attitudes that Hawthorne House scored the lowest, ranking third overall, that is equal to one, and more resident oriented than two, of the bed-sit homes. It was clear from the responses of the officer in charge to the attitude schedules that she adopted something of a Whole Person approach to both staff and residents.

For example in the critical situation analysis, whilst acknowledging that hurting residents was wrong and had to be stopped, she also wanted to find out if the member of staff was overtired or did not get on with the resident in some way. In relation to the question what was a good resident, she said, sighing, "Oh, that's hard: we've all got good and bad points. You could say a good resident is one who conforms - but why should they?" This was the officer in charge who arranged for the researcher to have coffee with the care and domestic staff on duty, "Because their pont of view about the home might be different from mine." She was also the one who planned the tour of the home to coincide with the residents being in the dining room having lunch; but she still knocked on their doors before entering their rooms.

At Hawthorne House then it seemed as if the relatively poor physical design and lack of policy document were more than off-set by the attitudes of the officer in charge and that the resultant residential environment was very nearly as resident-oriented as some of those achieved in the bed-sit homes.

Whilst these four homes, The Beeches, The Elms, The Poplars and Hawthorne House are not representative of the other fourteen homes, all of which had their own unique ways of operating, they do perhaps illustrate some of the main ways in which physical design, policy, practices and procedures and

attitudes interact and affect the overall quality of the residential environment. Tentatively it could be argued, from the evidence presented thus far, that physical design is important, but not to the exclusion of other factors; that whilst the presence of a policy document seems to bear little relationship to the achievement of a particular sort of residential environment, the existence of a clearly held policy does seem to; that practices and procedures appear to be influenced by physical design, policy and attitudes;and that attitudes seem to be able to overcome to a considerable extent poor physical design, or alternatively result in an institutionl environment despite better than average design features. The precise ways in which these factors interact appears to determine the quality of the environment overall.

The following sections describe in more detail the responses to the various schedules, before arriving at some conclusions about the nature of the interactions between the factors under consideration.

6.3 THE SCHEDULES

The Physical design schedule (see Appendix 5)

The scores on the physical design schedule ranged from 0 to 8. A maximum score of 11 would denote a physical design which would make a resident oriented regime very difficult to achieve. The individual scores are shown in Table 6.1, page 269.

TABLE 6.1 TABLE SHOWING PHYSICAL DESIGN SCHEDULE SCORES

Home number	score
1	4
2	4
3	5
4	4
5	7
6	6
7	5
*8	2
*9	0
#10	8
11	6
12	5
*13	2
#14	6
15	4
16	6
17	3
*18	1

* New bed sit homes

Old converted homes

(Home number 17, whilst not technically a bed-sit home, with its two double rooms and traditional-sized single rooms, was run in a very similar way to the bed-sit homes proper and indeed may be seen as a prototype for them. It is noticeable that its scores on all of the schedules are very similar to those of the bed-sit homes).

The schedule was straightforward to administer and score, and in the main the questions appeared to cover the most important physical design features. However, discussion during the visits led to the identification of several other features which were thought to be significant by the staff of at least some homes. These were:

1. The provision of keys so that residents could lock their rooms. When this practice was introduced in one home, The Elms, home number 9, it not only solved the problem of intolerance towards confused residents who wandered, but also encouraged domestics to negotiate cleaning arrangements with residents, a practice the officer in charge was trying to promote, since they had to find the resident to get the key.
2. The dining room space provided, although adequate for the number of people soon became grossly inadequate when a significant number of wheelchairs and zimmers were added. This was an almost universal complaint from old and new homes alike.
3. Even in the new homes there were some complaints about the size of lavatories, given the number of people who used wheelchairs. Also in one very new home with many good design features, the sluices were separated from the residents' bathrooms by a curtain only, which was not very conducive to dignity or privacy, in the view of the officer in charge.

4. The officer in charge of one home with a number of visually impaired residents talked about the quality and positioning of lighting.
5. Many homes had physical provision for a small shop and/or bar on the premises. Interestingly emphasis and use of them varied tremendously, as did the staffing (ranging from residents to staff to volunteers). One officer in charge (of home no. 18) who ran a very successful bar and shop, both in terms of heavy use and making a small profit, attributed her success to their being extremely well stocked and almost always staffed (by volunteers who had time to meet individual need. The shop, for example boasted it would obtain anything a resident wanted given time). This illustrated how physical provision alone did not guarantee successful use of facilities, but that when they were run in a way which met the individual needs of residents they became very popular indeed. In homes where this was not the case stocks were run down and the facilities staffed so infrequently that their use was, albeit inadvertently, discouraged.

In addition to the design features outlined above, another common theme was in relation to resources for physical provision. Repeatedly the researcher was told how certain curtains were provided from the proceeds of a fete, or

how redecorating was financed by funds designed for other purposes. Cuts in public expenditure meant that the physical upgrading of older homes often had to wait, or be financed by fund-raising activities. This resulted in an even greater variation in physical provision and raises many political questions about what is or should be provided by local authorities.

Almost all the officers in charge expressed the view that physical design significantly helped or hindered them in running the home in a resident-oriented way. Even small design features, such as the provision of display shelves in bedrooms, facilitated the personalisation of space. Certainly the overall impression was that physical design was very important and clearly some homes, particularly the newer ones, had significant advantages over others in this respect.

The practices and procedures schedule (see Appendix 6)

This schedule was perhaps slightly more difficult for the officers in charge to respond to since it reflected, far more than the previous one, on them themselves. There were sometimes long explanations given of why the key worker system, for example, was no good or why staff meetings were not necessary in the home. This suggested that, although care was taken to try to ask questions neutrally, people were of the opinion that some answers would be more acceptable to current thinking

than others. One officer in charge, of a very traditional home, actually said this and proceeded to criticise what is currently held to be good practice and to rationalise his own institutional practice, largely on the grounds of his long experience in the work having provided him with the knowledge of what was best for elderly people.

The scores for this schedule are given in Table 6.2 on page 274.

Again the newer bed-sit homes scored better than the others, although two older purpose build homes, one, number 17, the prototype mentioned above, and the other, number 7, scored equally well, suggesting perhaps that some physical disadvantages can be overcome. It was also interesting to note that the least resident-oriented scores were not found in the converted homes with more physical disadvantages (numbers 10 and 14) but in numbers 3, 4 and 5: all older purpose built establishments. Indeed one older purpose built home had recently had an annexe added, converted from part of the old workhouse which it had originally replaced. Whilst the building had obviously been considerably upgraded, it was interesting that the resultant accommodation was more spacious and afforded more privacy than the purpose-built main house.

TABLE 6.2 TABLE SHOWING PRACTICES AND PROCEDURES SCHEDULE SCORES

Home number	score
1	6
2	7
3	9
4	9
5	9
6	8
7	4
*8	4
*9	4
#10	7
11	6
12	5
*13	4
#14	6
15	5
16	5
17	4
*18	4

* bed-sit homes

old converted homes

Home number 17 is the prototype for the bed-sit homes.

The most significant questions appeared to be number 2; when do residents get up? and number 4: are bedrooms cleaned routinely by staff? Only a few mostly newer homes gave people a real choice of when to get up. This was achieved largely by offering residents breakfast in bed in addition to serving it in the dining room. One officer in charge, in home number 9, a new home which had inherited residents and staff from a smaller old converted home which was closed down, wanted to encourage more 'normal' going to bed and getting up times. She found that by serving hot drinks and a snack at 9.30 pm. rather than a couple of hours earlier she could easily encourage people to stay up and consequently get up later.

The routine cleaning of corridors and bedrooms was also more likely to be avoided in the newer homes, where negotiation with residents was more likely to occur. The allocation of keys to residents has already been commented upon in this context and appeared to facilitate such negotiation. Interestingly in the more traditional homes cleanliness was a matter of pride, whereas in some of the newer homes pleasure was obviously felt when residents felt sufficiently confident to ask that their room be left in a muddle, if that was what they wanted. One of the residents who showed the researcher around home number 9 was one such person: her room was crammed with old furniture with several drawers not properly closed and having clothes spilling out of them; and knitting,

magazines and plant cuttings were everywhere. On entering the room she said, "I know it's not very tidy but it's how I like it - like home." And it did indeed seem like her home.

Very few homes drew up individual care plans with or for residents (question number 11) except at a very informal level, although a few were attempting systematic reviews of at least some residents. Several people said this was an area they hoped to work on in the near future.

Most, but not all, homes operated a key worker system (question number 1). Its extent varied from bathing and personal interest to a much more sophisticated system involving the key worker in pre-admission work, responsibility for calling doctors and dentists and keeping personal records and reviews. Most found it a useful way to individualise the care given, although one officer in charge thought such a system unnecessary and in home number 3 several attempts had been made to introduce a key worker system with little success.

The Policy schedule (see Appendix 7)

Not all the homes by any means had a policy or philosophy statement. Those that did not were given a maximum score of 11. The four new bed-sit homes and their prototype, home number 17, all had county-produced policy documents which were in the main excellent, bringing their scores down to

0, 1 or 2. Home number 3 also had such a document, relating to the newly opened annexe converted from part of the old workhouse which had previously been used as staff accommodation. In addition homes numbered 13 and 17, and two older purpose built homes had individual pamphlets relating specifically to the home which were given to prospective residents. Home number 1 was also said to have such a pamphlet, but a copy could not be located so reluctantly a score of 11 was recorded. The two homes which had produced pamphlets, but which did not have a county produced policy document, were largely descriptive of physical facilities rather than indicative of their philosophies of care, and in fact served to reduce the homes' scores on this schedule only to 9. It seemed in these cases that a very real opportunity to communicate to prospective residents the philosophy of care they might expect in the homes had in these two instances been lost. Many of the officers in charge who did not have a pamphlet expressed interest in them and the motivation to draw one up. Indeed a couple were already in the process of being produced, although one had been sent many months previously to an adviser, on whose desk it had sadly remained. One officer in charge (of home number 14) said that she had thought of drawing up a pamphlet but the reality was so awful that she did not have the heart to write it. "How could you," she said, "write, 'You would have to share a room with a senile incontinent person'?" Many of the

officers in charge of the older purpose-built homes appeared to be unaware of the county-produced philosophy documents, or if they were aware of their existence said that they had never seen one. Many said that it sounded like a good idea that the county should have a general philosophy of care for its homes, and that they would welcome their use being extended to all homes and not just to the new ones. Inevitably, some saw the present distribution of the documents as further evidence of the county's lack of interest in the older homes.

Of course the existence of a good policy document does not guarantee resident oriented practices, see, for example, home number 3, and indeed several officers in charge experienced difficulty in locating theirs for the researcher. However, they probably were of value, particularly when setting up a new home, in giving staff guidance on what was expected and also in attracting the right calibre of staff, since many were sent out to prospective employees. Nevertheless it did seem that other opportunities for using such excellent documents to foster and promote resident oriented practices were being missed. Having said this, one home, number 13, The Poplars described above, was visited where at least one part of the document was being interpreted very literally, and where 'privacy' was being imposed on the residents, "because privacy is good for people." In this particular home it seemed as if the document or at least certain parts of it were being

applied blindly, without any clear understanding that underlying its recommendations was a belief in resident autonomy and self determination. Consequently in this home privacy was being imposed on residents against their wishes in as officious a way as in other homes people were forced to get up at 6 am. Thus despite many features usually associated with resident oriented practices being present, in fact the basic attitude was still 'we know best', and in this case the policy document was being used to support this position.

In one sense it seemed unfair to score so many homes 11 on this schedule, especially since the lack of such a document did not necessarily mean that no policy existed in the home. However, all the homes with a low score on this schedule had also achieved low scores on the practices and procedures schedule. On the other hand so too had some homes with no policy document (notably homes numbered 7, 12 and 15, Hawthorne House).

The attitudinal schedules

1. The critical situation analysis (see Appendix 9)

Most people found this situation credible and interesting, indeed one person accused the researcher of having peeped into her files to get the idea of the letter. The majority scored quite well on this schedule, the highest score being 6 and the lowest 0 (see Table 6.3 below, page 285).

Interestingly people were more concerned about the alleged 'cruelty' than about staff being 'too busy' to take the resident into the garden. Many officers in charge did not mention the latter incident at all. Overall views varied considerably about the seriousness of the situation. Reactions varied from, "It doesn't look as if there is anything seriously wrong with the member of staff's actions," to "I'd have to involve my line manager immediately because this is bordering on physical abuse." (Homes numbered 1 and 18 respectively).

A few officers were highly judgemental of the daughter or the resident, attributing to the situation the daughter's guilt about her mother being in the home and the resident's obvious desire to make mischief. Such interpretations had little if any evidence in the schedule to back them yet such assertions were sometimes made with vehemence. One woman, before even seeing the schedule, but after being told it concerned a letter of complaint from a relative, said, "I would say, 'If you can do it better madam take her home,' that always shuts them up." Others showed more sensitivity to the feelings of the resident, the member of staff and the daughter and accordingly scored lower. Some people who thought the member of staff had acted wrongly would, if that had proven the case, merely have told her she was not to act in such a way. Others thought of her training needs: both in lifting and in sensitivity. In general the schedule seemed to elicit

replies that appeared to give quite a good insight into people's views of residents and staff and their respective roles.

2. The character profiles (see Appendix 11)

Scores in this schedule again ranged from 0 to 6. To the researcher the most interesting responses were those relating to the characteristics of good or bad residents. A couple of people refused to accept the concept and justified their refusal articulately. Some said that they did not like the idea but then proceeded to describe 'good' and 'bad' residents in terms of the difficulty they presented to staff. Yet others had no qualms about the constructs and stated categorically that good residents were those who fitted into the home and bad ones those who made trouble. The questions about staff and officers in charge were less telling, but interesting nonetheless. Some people clearly thought they were good officers in charge, others thought they were far from perfect but knew what they were aiming towards. One head of home found the notion of a bad member of staff genuinely difficult. She said that she would simply not have bad members of staff: if they were that bad they would have to go! It took a great deal of prompting to get her to specify what 'that bad' would mean. Eventually she managed to explain that a bad member of staff would be one who gained pleasure from the "power of being in charge of residents," and someone who believed she knew what was best for residents, particularly

the frail ones. Interestingly this was the only time anyone explicitly mentioned power, although it was implicit in many of the responses.

Again this schedule appeared to give some insight into people's attitudes towards staff and residents.

3. The tour of the home (see Appendix 12)

This was perhaps the most enlightening attitudinal schedule of all: the range of scores was greater than for the previous two, being from 0 to 10. The contrast between responses to the earlier schedules and actual behaviour on the tour of the home was nowhere as pronounced as in the last visit of the pilot study; nonetheless differences did occur. It was surprising how many people did not knock at doors, did not introduce the researcher and told residents rather than asking them if the visitor could see round the home. On several occasions the researcher felt embarrassed as the officer in charge strode into a sitting area and proceeded to talk about the design, or, more rarely, even the inhabitants, without introducing his or her visitor. Interestingly this sort of behaviour was far more common amongst male officers in charge than their female counterparts, with the average score in this section being 4 for men and 2.7 for women.

The worst experience of all occurred in home number 4, The

Beeches, described above. The researcher went into one elderly person's room with the officer in charge who asked her how she was, then, without altering his voice at all, turned to the researcher and said, "We won't stay long or she'll tell us how she is for a long time," and then proceeded to walk out of the room. This sort of experience was, however, rare and some wonderfully warm exchanges were also witnessed and indeed participated in. In one home the researcher was introduced to the residents as, "My friend Stella," and in another as, "My tutor." When introductions were effected conversations became possible and many interesting ones ensued: one fascinating one about the origins of the name of the home by a person who came into the home for day care, and who in earlier years as a councillor had been instrumental in naming the home; one about a man's affinity with animals; one about how it felt to lose one's sight in later years; and one with a key worker about how she had felt when her favourite resident had died. In one home two residents quite spontaneously told the researcher how good the deputy was and how kind. This was apparent in the way she approached them, talked to them, touched them and perhaps most significantly, listened to them. In too many homes conversation was limited to a conventional "Are you all right?" to which any reply other than "Yes, thank you," was clearly unacceptable.

The final sixth category in this schedule was about control.

It seemed a crucial aspect which was not touched upon in many of the other schedules. Even in some of the more 'enlightened' homes, control of daily life still rested with the officer in charge. A good example of this was the situation of the two residents who wished to share a room in home number 13, The Poplars, but were not allowed to since 'privacy is good for people.'

In another home activities were greatly stressed, again in a home with many 'good' practices. The officer in charge believed that elderly people needed 'heightened stimuli' to enable them to 'harness the strengths of residential living.' This was in contrast to another officer in charge who said that over-stimulating people in their 80's and 90's who do not want to get involved in activities was 'quite simply cruelty.' In the first two examples above a 'we know best' attitude was still apparent even if it was a relatively enlightened 'we know best' compared with many of the more institutional practices. Both however deny the resident control over his or her own life, and were scored accordingly.

When the scores of the three attitudinal schedules had been calculated the scores were aggregated and divided by three to give a score comparable to those of the other three schedules. The aggregated scores ranged from less than 1 to 7 (see Table 6.3 below, page 285).

TABLE 6.3 TABLE SHOWING THE ATTITUDINAL SCHEDULE SCORES

Home	Critical situation	Character profiles	Tour analysis	Average
1	4	2	4	3.3
2	2	3	5	3.3
3	2	3	5	3.3
4	6	5	10	7.0
5	5	2	3	3.3
6	4	6	6	5.3
7	4	2	5	3.6
8	4	2	2	2.6
9	3	0	0	1.0
10	4	3	9	5.3
11	5	2	4	3.6
12	4	2	3	3.0
13	1	3	3	2.3
14	5	4	2	3.6
15	3	1	2	2.0
16	4	3	4	3.6
17	2	3	1	2.0
18	0	1	1	0.6

Kitwood (1980) gathered his data by tapes, post interview summaries and significant quotations. Later he processed these data not just mechanically in terms of their content, but also employing insight, interpretation and generally

more subjective methods in order to understand their meaning and significance. He treated these results as cumulative: together, he believed, they represented a valid picture. In many ways the attitudinal schedules represent a similar cumulative enterprise. Together they seemed to have come some way near to understanding the attitudes of officers in charge towards their residents and the way they saw their role vis a vis the staff. The reduction finally of such varied and interesting data to a number seems in some ways to do them less than justice. However some form of quantification was required in order to make the comparisons necessary to test the hypotheses.

The Analysis of Daily Practices Schedule (see Appendix 1)

In the original research home the Analysis of Daily Practices Schedule (Evans et al. 1981) was administered by two people, the researcher and the social services officer, from information and observations gathered over a fairly lengthy period of time and in consultation with several staff and residents. Where observation of practice and reported practice differed, observation determined the score given (see Sections 3.6 and 3.8). In contrast the eighteen survey homes were visited just once by the researcher, who administered the score very largely on the basis of the responses of the officers in charge to the schedule questions. Limited opportunities were afforded by the tour of the establishments to

observe staff attitudes to residents and some practices within the homes, but nothing on the scale of the period of observation to cover the waking day in the original research home. Nonetheless a few responses were later modified on the basis of such observations, particularly in relation to knocking on doors, question 2b3, and the infantilisation of residents (question 3c3).

It is probably for these reasons that the most institutional score of the survey homes was 32, compared with 34 for the first scoring of the original research home. It is the researcher's view that if the scoring in the survey homes had been undertaken under the same conditions as the first home the scores would have been consistently higher. Certainly home number 4 appeared more institutional than the original research home. On the other hand the survey conditions in the eighteen survey homes were remarkably similar and thus for the purposes of comparison (between the eighteen, not with the original research home) the results are probably valid. Nevertheless questions of judgement remain a problem with this instrument.

Some of the officers in charge obviously felt able to be more open than others in their responses: for example some answered categorically that infantilisation was avoided in the home. Others said that such practices would be considered

unacceptable but that they probably nonetheless went on in the home, particularly by one or two members of staff. Again the researcher had to exercise judgement in deciding how to score these responses, but a general overall impression gathered from the answers to other questions, from general discussion and from observation helped to guide the decisions.

If anything, the experience of administering the schedule 18 more times highlighted both its usefulness, as a relatively easy way to arrive at an overall evaluation of the environment of a home, and its weaknesses, in relation to the amount of judgement necessary to complete it.

In addition one question appeared throughout the survey not to result in a valid index of institution or resident-oriented environments. Question number 1b3 asks if males and females have separate lavatory facilities. The answer yes is said to denote a resident-centred environment. It is at least arguable that non-segregated facilities would be less institutional. Similarly several officers in charge criticised some questions on the grounds of their inappropriateness in relation to the levels of physical and mental dependency prevalent amongst present day residents. The two most frequently commented upon were question 2c2, asking whether any residents' money was controlled, and question 4h2, which asks whether residents organise any functions themselves.

Even the most resident-oriented homes had one or two residents whose confusion was such that relatives or staff had decided to keep back or bank their money. This did not, however, mean that the residents were kept without money in most instances but that it was given to them in small amounts, rather than in one weekly sum. Other residents themselves requested that their money be kept for them. The actual number of residents concerned varied considerably from over one half of all residents to just two or three: all homes however controlled the money of some. Similarly very few homes indeed had residents who organised outings or functions, although a handful did. It is difficult to judge how far these criticisms are a valid comment on the deterioration of residents since 1981 when the schedule was published or how far they are rationalisations of institutional practices. The consensus view of researchers working in this field is that overall residents have deteriorated relatively little in terms of physical and mental functioning (see for example, Allen 1984) but consistently, and almost without exception, practitioners say differently.

Other interesting criticisms of the schedule came from the officer in charge of home number 17, who paradoxically found it an extremely useful instrument to help her evaluate the regime in the home and decide on areas of practice that needed to be changed. This person, a student of the researcher,

suggested that some important areas were missing from the schedule and that the following questions could usefully be included:-

* Are residents encouraged to bring pets with them?
* Are there facilities for visitors to stay overnight/ for a meal?
* May residents enjoy loving relationships with one another without interference from staff?

Needless to say the answers to all these questions would, in the case of home number 17, be in the affirmative, but nonetheless they are indeed interesting areas which are not covered by Evans and his colleagues.

The researcher's main criticism of the questions themselves, apart from the amount of judgement required to answer them, centres on the issue of resident control, which has emerged as a central theme throughout this research. Whilst some questions do ask whether residents can control some aspects of their daily lives, such as when to get up and when to take a bath, others assume, as did some officers in charge, that certain features are necessarily good for people irrespective of what they themselves think about them. Thus questions 4h1 and 4i2, which refer to outings and activities, receive a low, that is resident-oriented, score if they are frequently embarked upon. This would mean that a home which practised enforced outings and activities would receive a more resident-

oriented score than one in which few people participated in activities and outings but did so, or not, from real choice. Yet underlying the assumption that outings and activities are good per se is an attitude of 'we know best' which characterises a Less Than Whole Person approach to residents. It assumes that because a person has needs in a specific area or areas which have resulted in her having to receive residential care, she is necessarily no longer able to make choices in all sorts of other areas of her life, and that other people are better equipped to make these decisions for her, since they know what is good for her. This is not, in the researcher's view, a resident-oriented approach to residential care, which is essentially a person-centred approach and which has at its core the assertion that it is the resident who should be in maximum control of her life, including a say in the decision about how much help and stimulation she requires, and by whom. As a result of these questions, homes numbered 1, 7 and 13 scored rather better than they might otherwise have done.

These criticisms notwithstanding, the schedule proved overall an effective and relatively easy method of evaluating the environments of the eighteen homes. Certainly the officers in charge expressed interest in it and several specifically asked for the results of the schedule to be communicated to them. This was done in a hand-written postscript to the letter

sent to all the respondents thanking them for their co-operation and help (see Appendix 14). As a result of this letter three additional officers in charge asked for the scores of their homes, one of whom also asked for a copy of the completed schedule and an identification of the areas of practice which needed working on within the home.

The scores, with a possible institutional maximum of 77, varied from 9 to 32, and in the researcher's view these figures reflect fairly accurately the comparative qualities of the environments in the eighteen homes. The total scores and the sub-totals for the four constituent sections (resident care, maximum 21; resident autonomy, maximum 21; resident/staff interactions, maximum 9; and organisational practices and features, maximum 27) are given below in Table 6.4, on page 293.

Although many homes' scores were fairly consistent across the various sub-sections, some differences did emerge. For example home number 4, which at 32 achieved the most institutional score overall, had a lower score than five other homes in the organisational practices and features section. Similarly home number 11, which had a relatively high score of 27 overall, achieved a low score of 1 in the resident autonomy section. This corresponds with Booth's findings using a different but essentially similar measure of regime. He found that few homes could "be labelled as uniformly good

or bad," (Booth 1985, page 169) and coined the term 'multiple regimes' to describe this phenomenon.

TABLE 6.4 TABLE SHOWING THE HOMES' SCORES ON THE ANALYSIS OF DAILY PRACTICES SCHEDULE

Home No.	Resident care	Resident autonomy	Resident/ staff interaction	Organisation	Total
1	7	5	0	4	16
2	6	6	2	5	19
3	10	6	3	8	27
4	13	8	4	7	32
5	9	4	4	11	28
6	12	6	3	9	30
7	8	2	1	5	16
* 8	6	2	2	3	13
* 9	3	3	0	3	9
# 10	11	6	3	5	30
11	11	10	1	5	27
12	6	5	1	4	16
* 13	6	2	1	5	14
# 14	9	6	1	8	24
15	7	4	1	3	15
16	5	5	1	8	19
17	6	3	1	2	12
* 18	6	1	0	5	12

* Bed-sit homes

Old converted homes

Table 6.5 gives the total Evans score together with the scores of the other schedules. The figures in brackets refer to the rank order of the scores (1 being the most resident oriented, 18 the most institutional).

TABLE 6.5 TABLE SHOWING THE SCORES OF ALL THE SCHEDULES

Home No.	Physical	Practices	Policy	Attitude (average)	Evans
1	4 (6)	6 (10)	11	3.3 (8)	16 (7)
2	4 (6)	7 (13)	11	3.3 (8)	19 (10)
3	5(10)	9 (16)	1	3.3 (8)	27 (13)
4	4 (6)	9 (16)	11	7.0(18)	32 (18)
5	7(17)	9 (16)	11	3.3 (8)	28 (15)
6	6(16)	8(15)	9	5.3(16)	30 (16)
7	5(10)	4 (2)	11	3.6(12)	16 (7)
*8	2 (3)	4 (2)	2	2.6 (6)	13 (4)
*9	0 (1)	3 (1)	0	1.0 (2)	9 (1)
#10	8(18)	7 (13)	11	5.3(16)	30 (16)
11	6(13)	6 (10)	11	3.6(12)	27 (13)
12	5(10)	5 (7)	11	3.0 (7)	16 (7)
*13	2 (3)	4 (2)	0	2.3 (5)	14 (5)
#14	6(13)	6 (10)	11	3.6(12)	24 (12)
15	4 (6)	5 (7)	11	2.0 (3)	15 (6)
16	6(13)	5 (7)	9	3.6 (12)	19 (10)
17	3 (5)	4 (2)	0	2.0 (3)	12 (2)
*18	1 (2)	4 (2)	0	0.6 (1)	12 (2)

* Bed-sit homes

Old converted homes

The scores to the Analysis of Daily Practices schedules were calculated after those of the other schedules, particularly the attitudinal ones, in an attempt to minimise researcher bias, especially in relation to 'proving' hypotheses.

An early consideration of the scores, revealed some interesting relationships. Most strikingly the four newer 'bed-sit homes' and their prototype home number 17, scored remarkably and consistently well on all the schedules, occupying first to sixth place in each one. This may be because the physical design encouraged resident-oriented practices or it may be because such homes with their explicit policy documents attract senior staff committed to resident-oriented values who can implement such practices. More probably however their relative success may be due to a combination of both factors. The causal relationship cannot be deduced from these data, but certainly amongst these five homes a clear relationship appeared to exist between physical advantage and resident-oriented practices, policy and attitudes of the officers in charge. Thereafter, however, the relationship between physical design and resident oriented practices was less clear. The obvious example is home number 4, The Beeches, which was sixth in terms of physical design but eighteenth on the Evans schedule. Here the relationship appeared to be between resident-oriented practices, or rather institutional ones, and the attitudes of the officer in charge, where the home was also ranked eighteenth.

The existence of a resident-oriented policy document at first glance did seem related to the score on the Evans schedule, especially, again, in the new homes. Here home number 3 provided an interesting exception. This was a home with a 'new' annexe (converted from old workhouse accommodation to provide spacious single bedrooms) and it was in relation to this annexe that the policy document was drawn up. In the researcher's view the officer in charge was unduly pessimistic about the practices in this home, which partly explains the relatively high scores on the practices and procedures and the Evans schedules. His own view was that he was hampered by lack of space and more particularly by staff and attitudes going back to the work-house, from which he too had come as 'Master.' Yet the annexe appeared to be operating in a much more resident-oriented way than the older purpose-built home with exactly the same staff. Perhaps in a sense it was unfair to include this policy document since it referred essentially to the new annexe and all the others related to homes in their entirety. Other homes,notably numbers 7, 12 and 15, achieved relatively low scores on the Evans schedule without the benefit of a policy document at all.

In addition to gathering data via the schedules, a decision had also been taken to see if there was any relationship between the professional qualification of the officer in charge and the quality of the residential environment as measured by

the Evans schedule.

An examination of these qualifications showed that the heads of 15 of the homes had some sort of qualification, whilst three had none. Five officers in charge had a social work or social services professional qualification: three had CSS, one CQSW and one a social science degree plus a post qualifying course in the care of elderly people. This last person was difficult to categorise, but seemed to fit better into this group than any other. A further six officers in charge had the older CRSW qualification (a one year full-time course no longer in existence); four others had a nursing qualification alone (SRN, SEN and/or RMN); and the final three had no professional qualification at all.

The average scores for those homes with officers in charge with no professional qualification was, to the nearest whole number, 21; for those with a nursing qualification 23, for those with CRSW 22 and for those with CSS or CQSW 14.

Interpretation of these scores must be approached with care since the numbers are so small. Nonetheless they do seem to lend support to the county's current training policy of working towards having all officers in charge professionally qualified with either CSS or CQSW. Beyond that, the results were surprising, particularly the relatively institutional

scores of those homes whose heads had CRSW or a nursing qualification (average scores 22 and 23 respectively) compared with those who had no professional qualification (average score 21). It is possible that the courses that led to these awards did not promote resident-oriented thinking or practices, but their relatively poor scores may equally be due to the length of time that had elapsed since the training was undertaken. Certainly the majority of these people had been in post for many more years than those with CSS or CQSW.

The schedules employed in the survey have been described and their usefulness analysed; overall they appear to have provided reasonably valid results and the scores from them seemed worthy of more sophisticated analysis.

On a more personal level the experience of visiting such a cross-section of homes within one county was a fascinating one. The researcher was, almost without exception, received with interest and enthusiasm, and was given open and free access to all manner of detailed information about the running of the homes. With a few exceptions it was a rewarding and stimulating experience and the researcher was extremely grateful for the hospitality and warmth extended to her by staff and residents alike.

6.4 ANALYSIS OF DATA

The purpose of undertaking the survey was to collect data relating to the quality of the environment (The Analysis of Daily Practices schedule, Evans et al. 1981), the physical design of the home, the procedures and practices, the policy document and the attitudes of the senior staff in order to explore the relationships between them.

More particularly two hypotheses had been formulated:-

* In order for a resident-oriented environment to be achieved it is necessary for the attitudes of the senior staff to be person-centred. It has been suggested (see Chapter 4) that this would entail a Whole Person (WP) attitudinal construct towards staff and residents.
* Such an environment will be facilitated if the following are also present:-
    - a physical design which encourages individuality
    - procedures and practices which foster individuality and self determination.
    - a well formulated official resident-oriented policy.

Evans et al. (1981) assert that the aim of their instrument, the Analysis of Daily Practices Schedule, is to:-

> "Judge particular organisation practices or features according to their tendency to facilitate or limit resident freedom, to facilitate administrative

> efficiency at the expense of resident needs, to regiment residents and subject them to block treatment, to depersonalise residents by eroding individual differences or limiting decision-making powers, to maintain social distance between resident and staff."

In order to make such a judgement they ask a battery of 78 questions about the home which are then coded according to whether the answers are suggestive of a resident- or institution-oriented environment. Of these questions, four relate directly to the attitudes of staff, and the answers to at least two will largely be determined by physical design features. The remaining questions relate largely to practices, although clearly they too will also be affected by attitude, policy and design, concentrating as they do on the residents' freedom to choose.

The use of the Analysis of Daily Practices schedule (Evans et al. 1981) in conjunction with instruments relating to practices and procedures, policy, physical design and attitude could thus be criticised in that the subjects of the instruments are not entirely independent of each other.

This criticism is particularly apposite in relation to the Evans instrument and the practices and procedures schedule: it could be argued that they are both attempting to 'measure' the same thing, although experience during the survey suggested that they did highlight different issues also and that together they gave a better understanding of the home than would either one on its own. Nevertheless, in

this section, for the reasons outlined above, the practices and procedures schedule was excluded from the analysis of data.

Returning to the other three instruments, those relating to physical design, attitudes and policy; it is clear that all three are likely to have an impact on the quality of the environment. Each will have a tendency to hinder or help the achievement of a resident-oriented environment. However, they are not the same as such an environment. It is conceivable that a magnificent design could be the venue for a punitive and institutionalising regime; equally even the most person-centred staff could be reduced to institutionalising practices by some extreme physical designs, dormitory living for example together with an acute shortage of staff. One could also envisage a superb policy document which bore little relation to the residential environment experienced by residents. What is of interest is the extent to which these three aspects, of attitude, physical design and policy, are predictive of the quality of the environment. For example, is one more predictive than the others, or are all three equally necessary for the achievement of a resident-oriented environment. One method of presenting the relationships between several factors is cross tabulation, which Yaremko, Harari, Harrison and Lynn (1982) define as 'the

tabulation of the number of cases that occur jointly in two or more categories' (page 49).

Cross tabulating the results of the three instruments with the Analysis of Daily Practices schedule, the close relationshipo between them is apparent (see Table 6.6, page 303).

Scores have been designated 'high', 'medium' or 'low' in a way which ensured that roughly one third of the homes fell into each category. This was not possible with the scores of the policy schedule since these tended to be either high (above 9) or low (below 3) when such a document did exist. This schedule can also be criticised in that the absence of a document does not necessarily mean the absence of a policy; conversely the existence of a document does not necessarily mean its contents are accepted as the real policy of the home.

Table 6.6 shows that most homes that score high or low on the Evans schedule also score high or low on the other three instruments (physical design, attitudes and policy). The exceptions are perhaps more interesting than the majority which predictably show a relationship between the scores. There are two homes, numbers 3 and 4, which score high on Evans but not on the physical design schedule, where they each achieve medium scores. On the policy schedule home number 4 scores high, not having a policy document, whilst home number 3 scores low, having a document, but one relating largely to a new annexe. (See Table 6.7, page 305).

TABLE 6.6 TABLE TO SHOW CROSS TABULATION OF THE SCORES OF THE EVANS SCHEDULE WITH THOSE RELATING TO THE PHYSICAL DESIGN, ATTITUDE AND POLICY SCHEDULES

HIGH EVANS SCORE 7			MEDIUM EVANS SCORE 5			LOW EVANS SCORE 6		
High Physical Design	High Attitude	High Policy	Medium Physical Design	Medium Attitude	Medium Policy	Low Physical Design	Low Attitude	Low Policy
5	5	6	4	3	0	5	6	5

Evans: High = 24+ score (7 homes)
Medium = 16-23 (5)
Low = 0-15 (6)

Physical design: High = 6+ (6)
Medium = 4-5 (7)
Low = 0-3 (5)

Attitudes: High = 3.6+ (7)
Medium = 3.0-3.3 (5)
Low = 0-2.6 (6)

Policy: High = 9-11 (12)
Medium = 3-8 (0)
Low = 0-2 (6)

Home number 3 was something of an enigma: it had an excellent policy document (low score), attitudes of the head of home which fell into the medium category, a medium score on physical design, yet a high score on the Evans schedule. It has already been suggested that the officer in charge was unduly pessimistic in his responses to the Analysis of Daily Practices schedule (Evans et al. 1981) but nonetheless this does not entirely explain the distribution of the various scores.

Home number 4, The Beeches, scored high on Evans, yet medium on physical design, nonetheless attitude and policy scores were also high, and in this instance the attitudes expressed were so institutional that it is unlikely that the existence of a policy document would have helped matters significantly. Thus one can suggest that in this home an average sort of physical design was affected adversely by the attitude of the officer in charge and the resulting environment was accordingly institutional in nature.

There are also two homes which scored high on Evans but not on the attitude schedule. These were number 3, the enigma referred to above, and number 5 which achieved a medium score on attitude though high on the others. The relatively low attitudinal score may well be due to the fact that the deputy, a CSS holder, accompanied the researcher on the tour of the home and it was apparent that she would have liked to effect more changes than she was able to do in her position.

There was only one home which scored high on the Evans schedule but not on the policy instrument: home number three, yet again. The policy schedule score was low and indeed the document was exemplary. However it was designed in the first instance to refer to a newly opened annexe and it was apparent that it had not yet been adopted in relation to the main home. It was perhaps inappropriate to assign such a score to the home generally on this schedule.

The scores of the seven homes which were given a high score on the Evans schedule can thus be summarised as follows:

TABLE 6.7 TABLE TO SHOW THE OVERALL SCORES OF THE HOMES WHICH ACHIEVED A HIGH SCORE ON THE EVANS SCHEDULE

Home Number	Evans	Physical design	Policy document	Attitude
3	H (27)	M	L	M
4	H (32)	M	H	H
5	H (28)	H	H	M
6	H (30)	H	H	H
10	H (30)	H	H	H
11	H (27)	H	H	H
14	H (24)	H	H	H

L = Low

M = Medium

H = High

Of the homes that scored low on the Evans schedule only one did not also score low on the physical design schedule where it had a medium score. This was home number 15, Hawthorne House, which scored high on the policy schedule, having no document, but low on the attitude schedule. It was apparent, whilst talking with the officer in charge, that, despite the absence of a policy document, she and her staff were very clear that the home's policy was resident-oriented, and undoubtedly her attitude had enabled her to overcome some of the physical disadvantages of the home. The score of this home on the Evans schedule was, at 15, the lowest excluding the bed-sit homes and their prototype home number 17.

This home, number 15, was also the only home to score low on Evans but not on the policy schedule where it achieved a high score. In this case the lack of a document did not indicate the lack of a resident-oriented policy, as suggested above (see Table 6.8, page 307).

Of particular interest, in relation to the first hypothesis (that to achieve a resident-oriented environment a person-centred attitude is necessary) is that of the six homes that achieved a low score on the Evans schedule, all also had a low score on the attitude schedule.

The scores of these six homes' scores can be summarised as follows, where the following pattern emerges (see Table 6.8, p.307).

TABLE 6.8 TABLE TO SHOW THE OVERALL SCORES OF THE HOMES WHICH ACHIEVED A LOW SCORE ON THE EVANS SCHEDULE

Home Number	Evans	Physical design	Policy document	Attitude
8	L (13)	L	L	L
9	L (9)	L	L	L
13	L (14)	L	L	L
15	L (15)	M	H	L
17	L (12)	L	L	L
18	L (12)	L	L	L

L = Low

M = Medium

H = High

In relation to the second hypothesis (that a resident-oriented environment is more likely to be achieved if, in addition to person-centred attitudes, the home is also characterised by a good physical design and a resident-oriented policy document) it can be seen that in general terms the hypothesis has been supported. Of the six homes which may be described as being resident-oriented (having scored low on the Evans schedule) five have low scores on the others also. Home number 15 is the exception, having a medium score on the physical design schedule, a high score on policy but low scores on the Evans and attitude schedules. It has already been suggested that it was the person-centred attitudes of the officer in charge which enabled the resident-oriented environment to

be achieved in this case, despite the relative disadvantages in terms of physical design, and that the lack of a policy document did not mean that a resident-oriented policy was not held in the home.

The scores of the other less resident-oriented homes also seem to support the two hypotheses. Whereas home number 15 suggests that the absence of a policy document does not necessarily mean the absence of a policy; home number 3 suggests that the existence of a document does not ensure resident-oriented practices if the attitudes of the officer in charge are not equally resident-oriented. Similarly whilst home number 15 suggests that relatively poor physical provision can be overcome by person-centred attitudes and that a resident-oriented environment can be achieved, home number 4 suggests that a medium score on the physical design schedule is counteracted by institutional attitudes and the result is an institutional residential environment.

Thus in general terms the evidence from the survey seems to support the first hypothesis in asserting the importance of attitude as a predictor of regime. Nonetheless, of the six homes that achieved low scores on the Evans schedule, and that have therefore been deemed resident-oriented, the one without the added advantages (of a good physical design and a resident-oriented policy document) scored the highest, 15, thus also supporting the second hypothesis that a

resident-oriented environment is easier to achieve if the other factors, apart from attitude, are also favourable.

In conclusion, whilst the data collected did not enable causal relationships to be inferred, in general terms the two hypotheses appeared to be supported.

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CHAPTER 7

CONCLUSIONS

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CONCLUSIONS

This research enquiry began with an historical overview of residential provision for elderly people (see Chapter 1) which provided the general context for an investigation into the causes of institutional dependence and an attempt to test out suggested methods of improving the ways in which elderly people's homes were run (see Chapter 2).

The experience from the action research undertaken in one home suggested that change, in the direction of more resident oriented practices, was possible. However barriers to change, in the guise of attitudinal constructs were also encountered (see Chapters 3 and 4).

The survey of the eighteen homes in the county was an attempt to explore the relationship between attitudinal constructs and other factors such as physical design, policy and practices and procedures in order to understand better how they interacted and affected the overall quality of the residential environment (see Chapters 4, 5 and 6).

This concluding chapter outlines what the research has shown in relation to greater understanding concerning the achievement of resident-oriented environments.

Firstly it needs to be asserted that the pursuit of resident-oriented environments is justifiable and desirable both ethically and empirically. Empirically it is justified because evidence suggests that resident well-being is thereby enhanced. Willcocks, Peace and Kellahar (1982) maintain, for example, that "consumer satisfaction is enhanced when personal identity is respected and individual rights and freedoms are asserted." Similarly Davies and Knapp (1981) write, "The weight of empirical evidence would suggest that resident self determination and personal control is necessary for, or at least strongly associated with, general well-being." Booth (1985) would challenge this position. He argues that he found no empirical evidence to support the view that differences in regime affect dependency levels. However his dependency scales largely focused upon physical or mental functioning and did not address other aspects of dependency, for example the lack of power to be self determining. Neither did he explore the relationship between regime and the felt quality of life as mentioned above. However, even if empirical evidence were not available, many commentators, including Ward (1980), would argue that such regimes should still be pursued since commitment to them is based on a value judgement regarding the desirability of treating residents as normal individuals having the same rights as any other citizens. This is the ethical justification. The pursuit of resident-oriented environments can thus be justified both in terms of elderly

people's rights to be treated as individuals and because they appear to improve their felt quality of life.

It is apparent, however, that such environments are not easily achieved, despite some considerable documentation of what is wrong. Many writers have drawn attention to the radical change in approach to the work that would be ncessary if such change were to be achieved. In Chapter 4 it is suggested that this would entail a 'radical renegotiation of roles,' away from doing things to people towards helping the resident 'to decide how she wants to live,' (Clough, 1981). Willcocks et al. (1982) maintain that in order to effect such change "staff must reinterpret their function and adjust from the role of care provider to facilitator."

It has already been established that achieving such change is not easy, however some physical design features may help. For example Willcocks et al. (1982) claim that, "The residential flatlet as a symbol of, and a setting for, resident individuality, should be sufficiently powerful to compel staff towards a reorientation of practice." Others, for example Marston and Gupta (1979),would make similar claims for physical reorganisation along group living lines. Thomas (1981), whilst acknowledging the importance of physical design, maintains that such provision in itself is not

sufficient to ensure resident-oriented practices. Many people also stress the importance of a consciously resident-oriented policy, which is translated into appropriate practices and procedures by senior staff committed to the attitudes reflected in such policies.

Dartington, Miller and Gwynne (1981) suggest that attitudinal constructs regulate the relationships between residents and staff, and that in a resident-oriented environment residents would need to be seen as having both autonomy and dependency needs. They maintain that staff operating from the pervasive Less Than Whole Person (LTWP) attitudinal construct define the whole person as less than whole on the basis of their physical dependency. "We impose our reality on people as a condition for helping them," (Dartington et al. 1981, page 116). The reason for this, they argue, is "the defensive dynamic of the carer," that is the need to treat others as less than whole in order to assert their own wholeness: the residents, then, represent an opportunity to do good. Such a LTWP attitudinal construct, particularly the tendency of the staff to believe that 'we know best,' has resulted in practice in staff exercising considerable power over the control of even minor aspects of residents' lives; practice which can easily be rationalised within the construct. Less easily assimilated, however, are more recent progressive ideas about the

fostering of independence and choice. It has been suggested (see Chapter 4) that such incompatibilities were resolved, in the home in which the action research was undertaken, by redefining independence to mean a sort of enforced physical 'independence', thus rendering it compatible with 'we know best': enabling the staff to pay lip service to such ideas without having their basic attitudes or practice seriously challenged. Such an analysis is supported by Lishman (1982, 1985, page 148) who says, "Activity and the maintenance of independence can, sometimes, become a tyranny, if disabilities and poor health make an individual unequal to the struggle."

Of the four attitudinal constructs, which Dartington et al. maintain regulate the majority of transactions between residents and staff, none acknowledges satisfactorily both autonomy and dependency needs, although the authors hint at an elusive fifth construct which might do so. Such a construct, if it were to emerge, would require a radical redistribution of attitudes and the subsequent renegotiation of staff/resident roles referred to earlier. In Chapter 4 this fifth construct was explored theoretically a little further in terms of its also being characterised by a state of interdependence between residents and staff and a devolution of power from staff towards residents. It was suggested that such an approach might be termed Whole

Person (WP). In the survey glimpses of the possibility of such a construct in practice were apparent, notably in home number 9, The Elms. Clough (1981) too, in his analysis of the residential task, suggests some characteristics of the Whole Person attitudinal construct in action when he describes the main function of homes being, "To provide a living base in which physical needs are met in a way which allows the individual maximum potential for mastery." (page 148).

Throughout this research and in the literature quoted above issues relating to power in staff/resident relations and different, often conflicting, definitions of dependency abound. Walker (1982) maintains that "whilst it is becoming more ... common for ... authorities to discuss the 'problem' of dependency in old age, there appears to be little agreement about the exact meaning of the term." (page 115). He goes on to clarify much of the confusion in his taxonomy of dependency in which he outlines four different ways of defining the word, which are, in his view, underpinned by a fifth: structural dependency. The four are firstly life cycle dependency, that is old people are dependent because they are not economically productive; secondly physical and mental dependency; thirdly political dependency in the sense of the restriction of an individual's ability to determine her own course of action, which is

based on an unequal power relationship between one individual and another; and, finally, financial and/or economic dependency on the state.

Walker's work is useful in the context of research into institutional dependence in that it demonstrates clearly that within residential establishments dependency is as much about power relationships as it is about physical impairment. It shows in fact that dependency is at least in part socially constructed, and it is not, as is often implied, synonomous with impairment. Most dependency scales for example employed within elderly persons' homes focus almost entirely upon physical impairment and/or disability and less frequently mental disorientation. Scores are accorded to such disabilities and the aggregate score is often expressed as a measure of dependence. Booth's (1985) dependency scales are examples of this. Yet people with identical physical impairments will vary in the extent to which they actually depend on others according to the interaction between the impairment and the environment, which will include society's, the staff's and the individuals' attitudes towards old age. Thus Walker concludes that, "Dependency is to a large extent manufactured socially," in other words that it is encouraged and sustained by social relations, which are also partly manifestations of an underlying structural

dependency in which certain groups, including elderly people, are denied or given restricted access to resources such as income, status and power.

Phillipson (1982) also argues that the notions of dependency in old age are socially constructed, in his view, to further the needs of a capitalist economy. For example governments encourage earlier retirement, and thus financial and life cycle dependency, in periods of high unemployment.

What this research has attempted to do, as advocated by Dartington, Miller and Gwynne (1981), is to separate out physical dependency needs from wider assumptions relating to general dependence in old age. In so doing it has challenged the politically dependent status so often ascribed to residents in elderly persons' homes, and the unequal power structure underlying it. In recognising that "dependency rests on the exercise of power" (Walker 1982, page 127) it asserts instead the right of elderly people to be treated as whole people and advocates the negotiation of role relations rather than the coercion implied in a generally dependent status.

Walker (1982) argues that words such as 'care' or 'help' disguise the power relation and this was graphically illustrated in the 'we know best' rationalisation of the use of

gentle force in the home in which the action research was undertaken.

Dartington et al. (1981) talk of the "defensive dynamic of the carer" underpinning the Less Than Whole Person attitudinal construct, where 'care' in the'we know best' sense is most apparent. Walker echoes this idea when he describes the person being depended upon as having, "Social and psychological needs, including the desire to be depended upon, which can create or increase dependence." (Walker 1982, page 127).

A consequence of the unequal power for the person with inferior status is that it "entails reduced opportunities for reciprocity and exchange in other social relationships,"(Walker 1982, page 127) thus further amplifying the stigma of dependency. This, too, was illustrated in many of the homes visited during the survey stage of the research and significantly it was at The Elms, the home where the Whole Person approach appeared most in evidence,that the researcher was given something (flowers and gardening tips) by a resident.

In a society where independence is a "powerfully sanctioned value" (Walker 1982) dependent people's social status will be undermined and dependency will be seen as stigmatising. The Whole Person attitudinal construct, in asserting the normality and desirability of interdependence for staff

and residents alike, challenges this view and focuses instead on their mutual well-being.

The survey lent support to the suggestion that attitudes were crucial as predictors of regime in comparison with other factors. Thus, for example, one home (number 4, The Beeches) with better than average physical design, had an officer in charge with many LTWP attitudes and the most institutional environment of all the homes surveyed, whilst another home (number 15, Hawthorne House) with very similar physical provision, but an officer in charge who adopted a more person-centred approach to residents, achieved a much more resident-oriented environment. However even more resident-oriented environments were achieved when all the factors, physical design,attitude, policy and procedures, were positive, as was the case in home number 9, The Elms. It was thus possible to identify the optimum factors for the achievement of a resident-oriented environment, and as predicted by Thomas (1981), these factors proved to be multi-dimensional.

On the other hand the action research, undertaken for the case study, demonstrated that even when all the factors were not entirely positive it was possible to intervene in such a way as to bring about some change in the direction of more resident-oriented practices, even if such change was limited by attitudinal constraints. Thus, even in a traditionally

designed and staffed home, run on an essentially routine-driven basis, change was possible.

This evidence, that change in a positive direction is possible, is particularly important if Anne Parker (1984) is right in her analysis that the future for local authority residential homes lies not in, "Wholesale development of new Part III accommodation," but as an "important, expensive but residual component in the range of services provided for the elderly," catering largely for very old people with physical and/or mental frailties.

The experience of working with the staff group, with the explicit aim of trying to increase resident-oriented practices, demonstrated that some ways of bringing about change were more effective than others. For example change brought about by what Kemmis (1981) calls an "arrested action research loop" was less likely to be sustained than when the loop was completed by the change in practice being brought back to the group after its implementation for re-evaluation and further decision making. Equally, the resistance of some people to change and the inevitability of unforeseen problems were also demonstrated. On the other hand, the research also showed that when people were fully involved in decision making and when preparations for change were carefully undertaken, change could be accomplished, particularly

when the starting point was a clearly agreed set of values and principles to guide practice. In general terms the case study supported Douglas's contention (1976) that, "Groups can be used to effect changes in the attitudes and behaviour of individuals." However, as referred to above, it also showed that when expressed values and values in practice differed because of an essentially LTWP attitudinal construct people were more resistant to change.

On a more individual level staff seemed enabled to change to the extent to which they felt themselves and their views to be accepted, valued and understood. This corresponds with "the core facilitative conditions" which Rogers (1961) and other humanistic psychologists maintain are necessary for any human growth or development to take place. The paradox is that once people feel their sometimes rigid views are understood they are somehow freed to move towards more flexible approaches to people. This was a most important piece of learning reinforced by the work with the staff team. Change cannot easily be imposed on people; sabotage is easily accomplished, particularly within a residential setting. Any attempts at change, it seemed, had to start where people were and move at a pace which could be accommodated by them. This was an example of how practice theories of effecting change and underlying theories of practice about the psychology of change and the nature of people, proved

useful in practice.

Resident-oriented environments, then, can be encouraged by such factors as physical design, policy and procedures, particularly if they are accompanied by senior staff with complementary attitudes. Even within more traditional homes moves in the direction of more resident-oriented practices are possible. However such new ways of working, as well as having radical implications for individual residents and members of staff, also have major implications for providing agencies. Willcocks et al. (1982) maintain, for example, that staff would need help and support to negotiate more resident-oriented ways of working which would clearly increase the demand for and necessity of effective staff supervision. They also point out that in a period of economic constraint, people are being maintained in the community longer and are therefore frailer on admission to residential care. Thus local authorities would need to increase resources, both in terms of equipment and staffing, if the physical needs of the frailer residents were to be met "without eroding into the time devoted to the new kind of working." There are, then, major support and resource implications for agencies committed to resident-oriented ways of working, which need to be addressed at policy level.

Thinking through such resource considerations is clearly a priority in terms of further research in this area; as is additional work with staff in promoting the Whole Person attitudinal construct.

The specific conclusions arising from this research project, which might be of use to providing agencies wishing to promote more resident-oriented environments, could be summarised as follows:-

1. Physical design helps, but it is not in itself sufficient.
2. A Whole Person attitudinal approach to residents on the part of senior staff is crucial: this involves going beyond paying lip-service to certain aspects of resident-oriented practice to working through the implications of what dependency and autonomy really entail for staff and residents, and renegotiating roles accordingly.
3. A policy document is less important than a coherently understood policy. Nonetheless, more use of these often excellent documents could be made in training sessions to ensure that staff fully understand and work through the practice implications of resident-oriented policies.
4. Agencies need to support, and be seen to support, risk taking, which is one inevitable consequence of more resident-oriented practices. (see for example Brearley 1982).

5. Staff will need help and support in re-negotiating their roles with residents: effective and regular staff supervision needs to be built in.
6. As residents become frailer, greater resources, both of staff and equipment, will be required to meet the growing physical dependency needs of residents as well as their autonomy needs.

Much has been written, not least in this conclusion, about the difficulties, at many different levels, involved in moving towards more resident-oriented environments. Such an emphasis on the difficulties, however, should not undermine the value of the goal or its pursuit. Thus both at the beginning and the end of this research is an assertion of the belief in the right of elderly people to determine as much about their lives as they are able, or, as Clough (1981) expresses it, "The fundamental right is for the resident to have a say in planning for her own life." Equally there is the contention, supported by empirical evidence, that such rights are more likely to be exercised in resident-oriented environments, thereby necessitating the challenge of more institutional regimes. "Egalitarian forms of social organisation reflecting the importance of challenging authoritarian relationships need to be created." (McLeod and Dominelli 1982). Essentially these two assertions constitute much of the assumptive framework underpinning

this research endeavour, which makes no claims to value neutrality.

These concerns, of the rights of people to be treated holistically, have in consequence also been reflected in the research process itself. An enquiry such as this makes it impossible and indeed undesirable to separate research from intervention. Attempts have been made therefore to ensure that the methodology itself was ethical also, if possible leaving the people concerned "with increased insight and personal autonomy." (Kitwood 1980).

Inevitably, given the nature of the substance of the research, the major focus has been on qualitative enquiry, seeking to understand the complexity of the variety of interacting factors which have a bearing on the quality of the residential environment.

Nonetheless attempts were made to quantify some of the data in order to facilitate comparative analyses, both between the various factors as predictors of regimes and between individual homes. In many ways the methodology employed was unconventional, and could be criticised for its lack of objectivity; yet this lack, expressed instead as commitment, is also its strength. The contention is that the knowledge and understanding which has resulted from this

enquiry, concerning the achievement of resident-oriented environments, is both academically rigorous and valid, guided as it was by a belief in the residential task being, "To encourage the individual to decide how she wants to live." (Clough 1981).

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APPENDICES

APPENDIX I: ANALYSIS OF DAILY PRACTICES SCHEDULE

AIM: to judge particular organisation practices or features according to their tendency to facilitate or limit resident freedom, to facilitate administrative efficiency at the expense of resident needs, to regiment residents and subject them to block treatment, to depersonalise residents by eroding individual differences or limiting decision making powers,to maintain social distance between residents and staff.

CODING: within each category the extent to which that practice is institution-oriented or resident-oriented is assessed on the basis of observations and interviews with residents and staff. Each question is to be answered according to what happens generally in the home. For each question, Yes = 0 and No = 1. Total 78 questions.

I. RESIDENT CARE (21 questions)

a1 Do residents have a choice of when they are bathed?

a2 Do residents have a choice of who bathes them?

a3 Can able residents bathe without permission?

a4 Can able residents bathe in private (apart from a necessary staff helper)?

b1 Are residents toileted according to their individual needs? (Routine toileting at set times, code 1)

b2 Are residents toileted in private (apart from staff helper)?

b3 Are males/females toileted in separate facilities?

b4 Is each toileted resident attended throughout the procedure by only one staff member? (Conveyor belt system, code 1)

c1 Is there a choice of meals?

c2 Do residents receive food as soon as they sit down? (If residents have to wait until everyone is seated, code 1)

c3 Can residents eat with whom they wish?

c4 Do staff eat regularly with the residents?

c5 Are there facilities for the disabled to feed themselves?

d1 Can residents choose when to go to bed?

d2 Do staff attend promptly when resident needs help retiring?

d3 Is there extensive use of sedation? (yes = 1, no = 0)

e1 Can able residents choose when to get up?

e2 Can disabled residents choose when to get up?

e3 Are residents brought tea if they wish it?

e4 Do staff routinely dress many residents? (yes = 1, no = 0)

e5 Is breakfast available for residents as soon as they get up?

2. RESIDENT AUTONOMY (21 questions)

a1 Do residents choose what to wear each day?

a2 Do residents choose the new clothes allowed them by the local authority?

a3 Are facilities provided for residents to buy/order additional clothes if they wish?

a4 Are clothes generally kept in good state of repair?

b1 Can residents choose a private or shared room?

b2 Can residents visit their own rooms at will?

b3 Is there reasonable privacy for residents in their own room? (if observation windows/staff don't knock, code 1)

b4 Have the majority of residents personalised their own rooms? (pictures and photographs don't count; evidence must consist of furniture, rug/bed cover or many smaller personal items together)

c1 Do residents collect their own pensions?

c2 Can all residents spend their money as they wish? (if money controlled by matron, or if restrictions are placed on certain residents, code 1)

c3 Do staff help the disabled/mentally infirm to buy what they wish?

d1 Are ambulant, lucid residents allowed to go out of the home without permission or without informing staff?

d2 Can residents stay out as long as they wish ? (if curfew, code 1)

d3 Do staff often accompany disabled/mentally infirm residents?

e1 Do residents have access to tea making facilities?

e2 Do residents have control over communal T.V./radio?

e3 Do residents have access to telephone?

f1 Are all communal areas available to all residents? (if segregated, code 1)

f2 Are other areas (e.g. kitchen) open to residents?

f3 Can residents choose where to sit in lounges?

3. RESIDENT/STAFF INTERACTIONS (9 questions)

a1 Does matron/deputy regularly chat to residents?

a2 Do residents discuss personal matters with staff?

a3 Do staff regularly communicate with residents for social purposes? (if communication mainly instructive/informative, code 1)

b1 Are residents generally addressed only by their Christian names? (yes = 1, no = 0)

b2 Is matron known to most residents by her name? (if title only, code 1)

b3 Do most able residents know the names of some staff?

c1 Do staff amongst themselves display accepting respectful attitudes to residents? (if critical, hostile or distant, code 1)

c2 Do staff avoid generalised terms for categories of residents (e.g. the 'babies', the 'incontinents')?

c3 Do staff avoid demonstrating infantilisation of residents in their attitudes to them?

4. ORGANISATIONAL PRACTICES AND FEATURES (27 questions)

a1 Are pre-admission visits by prospective residents a general occurrence?

a2 Does matron/staff generally visit prospective residents at home?

a3 Are new residents introduced to staff and other residents?

b1 Does a residents' committee exist?

b2 Do staff and residents meet to discuss issues?

b3 Are issues brought for decision to residents by matron?

c1 Are there regular staff meetings?

c2 Are care staff involved in admissions, case conferences etc.?

c3 Do staff control their daily work routines?

d1 Does a formalised complaints procedure exist?

d2 Does an informal opportunity for complaining exist?

d3 Can residents complain to S.S.D. management without acting through matron?

e1 Can residents freely retain their own G.P.

e2 Do residents see V.M.D. by appointment or on request? (if en masse or with group regimentation, code 1)

e3 Is there evidence that minor medical problems are properly treated? (e.g. if ill-fitting dentures, inadequate spectacles, hearing aids etc., code 1)

f1 Are the furnishings pleasant and varied (if furnishings uniform, regimented, code 1)

f2 Are facilities adequate for disabled residents? (e.g. adequate handrails, room for wheelchairs, colour coded doors, lift etc.)

f3 Are pleasant gardens surrounding the home?

g1 Are visiting times unrestricted?

g2 Is the number of visitors unlimited?

g3 Are there facilities for residents to see visitors privately?

h1 Are regular outings/functions a feature of the home? (at least once a month)

h2 Do residents organise any functions themselves?

h3 Are residents consulted before outings/functions are decided upon?

i1 Do residents undertake tasks in the home (e.g. cleaning, own small laundry)

i2 Do many residents undertake individual activities?

i3 Are facilities/materials/teaching regularly available to residents (e.g.library service, visiting teachers etc.)

(SOURCE: Evans et al. 1981)

APPENDIX 2: THE COMPLETE SCHEDULE SCORES

	FIRST EVALUATION			SECOND EVALUATION		
	RESEARCHER	S.S.O.	AGREED	RESEARCHER	S.S.O.	AGREED
1.	RESIDENT CARE					
a1	1	0	1	1	0	0
a2	1	1	1	1	1	1
a3	1	1	1	1	1	1
a4	0	0	0	0	0	0
b1	0	0	0	0	0	0
b2	0	0	0	0	0	0
b3	0	0	0	0	0	0
b4	0	0	0	0	0	0
c1	1	1	1	1	1	1
c2	1	1	1	0	0/1	1
c3	1	1	1	1	1	1
c4	1	1	1	1	1	1
c5	0	0	0	0	0	0
d1	1	0	1	0	0	0
d2	1	0	1	0	0	0
d3	1	0	0	0	0/1	0
e1	1	1	1	1	1	1
e2	1	1	1	1	1	1
e3	1	1	1	0	0	0
e4	1	0	0	0	0	0
e5	1	1	1	1	1	1
	15	10	13	9	9	9
2.	RESIDENT AUTONOMY					
a1	0	0	0	0	0	0
a2	cancelled					
a3	0	0	0	0	0	0
a4	0	0	0	0	0	0
b1	1	1	1	1	1	1
b2	0	0	0	0	0	0
b3	0	0	0	0	0	0
b4	1	1	1	0	0	0
c1	1	1	1	1	1	1
c2	1	0	1	0	1	1
c3	0	0	0	0	0	0
d1	1	1	1	1	1	1
d2	0	0	0	0	0	0
d3	1	1	1	0	0/1	1
d4	0	0	0	0	0	0

e1	0	0	0	0	0/1	1
e2	0	0	0	0	0	0
e3	0	0	0	0	0	0
f1	0	0	0	0	0	0
f2	1	1	1	1	0/1	0
f3	1	0	0	1	0/1	0
	—	—	—	—	—	—
	8	6	7	5	6	6
	—	—	—	—	—	—
3.	RESIDENT/STAFF INTERACTION					
a1	0	0	0	0	0	0
a2	0	0	0	0	0	0
a3	1	0	1	0	0	0
b1	0	0	0	0	0	0
b2	0	0	0	0	0	0
b3	0	0	0	0	0	0
c1	1	0	1	0	0/1	1
c2	0	0	0	0	0	0
c3	1	0	1	1	0	0
	—	—	—	—	—	—
	3	0	3	1	0.5	1
	—	—	—	—	—	—
4.	ORGANISATIONAL PRACTICES AND FEATURES					
a1	0	0	0	0	0	0
a2	0	0	0	0	0	0
a3	0	0	0	0	0	0
b1	0	0	0	0	0	0
b2	1	1	1	0	0/1	0
b3	0	0	0	0	0	0
c1	0	1	1	0	0/1	0
c2	1	1	1	0	1	1
c3	1	0	1	1	0	0
d1	1	1	1	1	0/1	1
d2	0	0	0	0	0	0
d3	0	0	0	0	0	0
e1	0	0	0	0	0	0
e2	0	0	0	0	0	0
e3	0	0	0	0	0	0
f1	0	0	0	0	0	0
f2	1	0	0	0	0/1	0
f3	0	0	0	0	0	0
g1	1	0	1	0	0	0
g2	0	0	0	0	0	0
g3	0	0	0	0	0	0

h1	1	0	0	0	0	0
h2	1	1	1	1	1	1
h3	1	0	1	0	0	0
i1	1	1	1	1	1	1
i2	1	1	1	1	1	1
i3	1	1	1	1	0/1	1
	—	—	—	—	—	—
	12	8	11	6	6.5	6
	—	—	—	—	—	—
TOTALS	38	24	34	21	22	22

APPENDIX 3 : AN OUTLINE OF THE SESSIONS WITH THE STAFF:

a. the planned programme

b. the actual programme

c. the issues raised.

Session 1: 1.11.83 GROUNDRULES AND VALUES

a. Thanks for access to home during observation period; negotiation of group groundrules; clarification of researcher's role; exploration of goals and values to guide practice; decisions about which area of practice to examine first.

b. Thanks for access; negotiation of groundrules; researcher's role; goals and values to guide practice; decision to hang poster of values in office; decision to start by looking at early morning practices.

c. Negotiation of groundrules
Purpose of residential care
Values to guide practice
Leadership style.

Session 2: 9.11.83 EARLY MORNING PRACTICES

a. Feedback on Analysis of Daily Practices Schedule score; give values poster to group for office; consideration of early morning practices; decisions to change, if any.

b. Feedback on schedule score; further discussion on

values and constraints; beginning to examine early morning practices; decision to invite night staff to next meeting.

c. Feedback of information
Constraints versus values
Readiness to change
Consultation.

Session 3: 16.11.83 EARLY MORNING PRACTICES

a. Welcome night staff; examination of getting up procedures in relation to agreed values, via four participative exercises.

b. Welcome night staff; 3 exercises only completed; members asked to complete fourth individually by next week; decision to invite night staff again next week as task incomplete.

c. Start where people are
Change takes time
Involvement and commitment
The use of participative exercises.

Session 4: 23.11.83 EARLY MORNING PRACTICES

a. Feedback on individual responses to exercises; researcher's comments re. values; suggest asking residents their views; begin to make decisions about how early morning tasks to be accomplished in future.

b. Feedback from exercises; researcher's comments re. values; decision to ask for residents' views; decisions incomplete.

c. Need to allow expression of fears
Use of creativity to overcome constraints
Resident participation
Values in practice.

Session 5: 30.11.83 EARLY MORNING PRACTICES

a. Recall 'ideal' getting up; feedback from officer in charge re. residents' views; complete decisions about early morning tasks; ask officer in charge to implement; check on values into practice; decide on next week's subject; thank night staff for attending.

b. Recall 'ideal' getting up; residents' views received; decisions made about early morning tasks; officer in charge asked to implement changes; decision made to be open about difficulties in implementation; thanks to night staff for attending; decision to look at key worker system next.

c. Receiving feedback
Decision making
Being open about difficulties
Preparing for change
Effecting change.

Session 6: 6.12.83 KEY WORKER SYSTEM

a. Feedback on values into practice; need for individual practice and procedures to reflect values; the key worker system in relation to agreed values; exploration of how key worker system might be developed in the home.

b. No feedback; the need for individual practice and procedure to reflect values; the key worker system; decision to develop the key worker system to include pre-admission work, recording, care programmes, reviews, personal care and talking socially to residents; decision taken that group members to provide the opportunity for residents to talk to them during next week; decision to return to key worker role next week.

c. Individual practice and procedures need to reflect guiding values

The key worker system

Information giving or enabling function of leader

Sharing feelings in the group

Guilt about 'just' talking.

Session 7: 13.12.83 KEY WORKER SYSTEM

a. Feedback of talks with residents; evaluation; suggestion to look in more detail at skills needed by key workers during next few weeks; sherry and mince pies.

b. Feedback of talks with residents; information needs of staff - access to records; talking about painful feelings; general consensus that talking is helpful and valuable; decision to look at helping people, recording, care programmes and reviewing in next few weeks; sherry and mince pies.

c. Sharedmeaning of words, especially 'independence'
Client centred or staff-centred conversation
Directive or non directive
Access to records
Avoidance of painful feelings.

Session 8: 11.1.84 KEY WORKER: helping skills

a. Principles of helping people; exercise on characteristics of helping person; need to express feelings, including painful ones; empathy; listening; reflecting; reflecting exercise; suggestion to practice listening and reflecting during week.

b. Principles of helping; exercise on characteristics of a helping person; expressing painful feelings; empathy; listening; reflecting; decision to practise listening and reflecting during week; senior staff agreed to reach decision re. access of files by next week.

c. Principles of helping
People's own feelings: individuality

Access to records/information

Need to express feelings

Challenging fellow group members

Session 9: 18.1.84 KEY WORKER: record keeping

a. Report back of listening and reflecting; recall decisions re. next few weeks; receive decision from senior staff re. access to files; how to keep records; recording exercises; decisions about records in home.

b. Report back from listening exercises; decision by senior staff that all care staff should have access to residents' files; recording; decisions about records to be kept in home: pen picture, diary, records, care programmes and reviews; confidentiality within a team; decision to write pen pictures for next week.

c. Trust and self disclosure

Open access to information

Confidentiality

Feedback.

Session 10; 25.1.84 KEY WORKER: care programmes

a. Feedback on pen pictures; guidelines to be decided; care programmes; observation, assessment, what needs to be changed, method, evaluation and review; meaning of independence: maximising physical mobility or self determination; care programme exercise.

b. Feedback on pen pictures; guidelines decided; care programmes; definitions of indpendence, 'gentle force'; decision to work on one care programme in detail next week; early morning practices feedback; decision to postpone next week's programme and invite night staff to discuss changes in early mornings.

c. Meaning of independence
Control versus client-centred care
Need for feedback
Need to ventilate feelings
Effect of 'new' member on group.

Session 11: 1.2.84 EARLY MORNING CHANGES: EVALUATION

a. Welcome night staff; importance of communication; explanation of new procedure; exercise: one good thing, one bad thing; discussion of issues; resolution of problems if possible.

b. Welcome to night staff; importance of communication; explanation and modification of new procedure; exercise: one good thing, one bad thing; discussion and decisions.

c. Communication
Denial
Effect of night staff on group
Different interpretations of written instructions: one way communication only.
Decision making.

Session 12: 8.2.84 KEY WORKER continued: care programmes

a. Any unresolved issues re. mornings; devise care programme for one resident; review suggestions for key worker; make decisions on content of next three weeks.

b. Feedback re. early mornings; devised care programme for one resident; reviewed suggestions re key worker; decision to look at key worker's role in pre-admission and admission work next week.

c. Small changes
Resistant attitudes
Individualising care
Staff-centred practice
Control.

Session 13: 15.2.84 KEY WORKER: pre-admission work

a. Pre-admission and admission work; involvement of key worker; suggestions from literature; individuality; loss; identification of present practice and where key worker might be involved; decisions about how to change.

b. Pre-admission work and admissions; involvement of key worker; suggestions from literature; individuality; loss; identification of present practice and where key worker might be involved; decision to pursue further next week; researcher to visit team leader.

c. Preparation for admission

Clear honest communication

Individuality

Choice/control

Session 14: 22.2.84 KEY WORKER: admissions

a. Report of visit to team leader; fantasy exercise re. admission feelings; what would help; useful information/ leaflet; first day in home; decision re. next week; need to include time for evaluation.

b. Report of visit to team leader; fantasy exercise re. admission feelings; unanswered questions; welcoming approach; key worker's involvement in pre-admission work; decision to look at activities and evaluate sessions next week.

c. Communication

Feelings

Empathy

Information

Expectations

Session 15: 29.2.84 ACTIVITIES AND EVALUATION OF SESSIONS

a. Activities; opportunities; choice; layout of chairs to encourage communication; small groups not large enforced groups; evaluation.

b. Activities; large or small groups; enforced or freedom of choice; staffed or unstaffed; opportunities; arrangement of chairs; social talk; provision of staff and material; possible activities; encouraging/ forcing; right to say no; evaluation; decision to carry on process using sessions as a model.

c. Opportunities

Choice

Encouragement/force

Size of group

Evaluation.

APPENDIX 4: THE EXERCISES EMPLOYED DURING THE GROUP SESSIONS

1. Negotiation of groundrules for the group. Poster put up at each group session

   Session 1

2. Negotiation of values to guide practice. Poster put up at each group session and in between sessions put up in care officer where it is still.

   Session 1

3. Exercise in pairs: what is a 'good' getting up and a 'bad' getting up for you?(Showed importance of individuality and choice).

   Session 3

4. Exercise in small groups of three or four; forget constraints, imagine you are a resident in the home and decide on an ideal getting up, bearing in mind the agreed values and thinking in terms of: waking, going to the lavatory, having a cup of tea, washing, dressing, making the bed and having breakfast.
   Feedback to large group. (Focus on values rather than constraints was encouraged by this exercise; again the importance of individuality was emphasised). Was recorded on a large poster and put up in the office for several weeks.

   Session 3

5. Hopes and fears exercise. Members were asked to write anonymously on a piece of paper, "What I hope we will

decide to do is ...." and, "What I fear we will decide to do is ..." The papers were then collected in and read out (see pp.151, Chapter 3.7).

Session 3

6. Individuals given a sheet of paper (copy below: Table 1) and asked to fill in boxes. The following week the results were collated and recorded on a large poster. A summary was provided of people's responses. This, together with residents' views, was used to guide decision-making about changes in early morning practices.

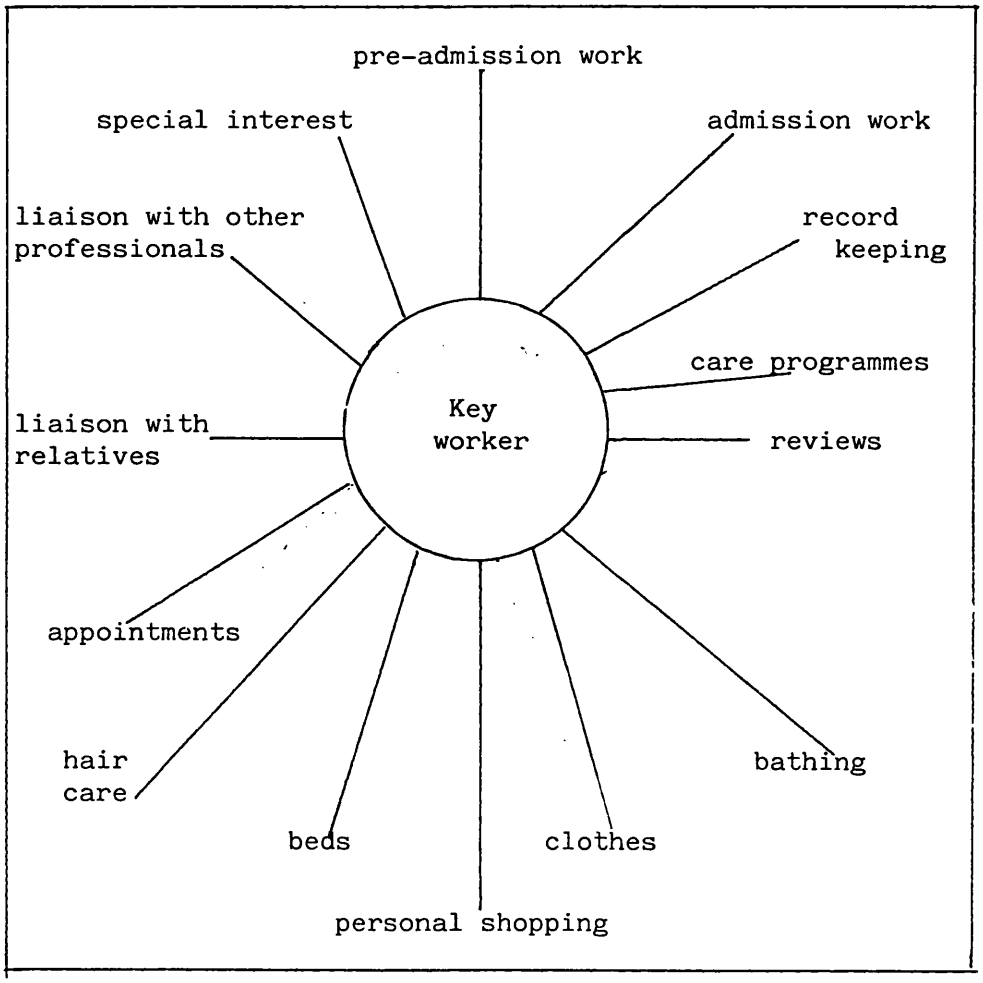
Table 1

TASK	When	by Whom	Where	How Why (values)
Waking up				
Toilet				
Cup of tea				
Washing				
Dressing				
Breakfast				
Making bed				

Sessions 3 and 4

7. Wall chart of possible key worker tasks provided (see Table 2 below) The group was divided into three smaller groups to discuss which aspects of the key worker role they would like to develop in the home. General feedback followed and decisions were made.

Table 2



Session 6

8. Exercise in pairs recalling the characteristics of someone group members turned to (or would have liked to turn to) when they were in trouble. This led to discussion and the identification of the characteristics of a helping person.

Session 8

9. A listening exercise in pairs: describe to your partners the sort of person you find it difficult to work with. The listener's task was to listen and make the speaker feel understood. This exercise was used to give people practice in listening and reflecting skills and to encourage empathic understanding.

Session 8

10. Individual preparation of pen pictures of one resident: this exercise was used to provide practice in recording and to arrive at agreed guidelines for the format of pen pictures and other records key workers might keep.

Session 10

11. An exercise in which members were asked to write on a piece of paper one thing that had gone well with the new early morning procedures and one thing that had gone badly (see page 157, The group sessions with the staff). The papers were collected together and distributed for discussion. The purpose of this exercise was to get into the open both positive and negative feelings about the new early morning practices, in

order to evaluate the changes and to modify them as necessary.

Session 11

12. An exercise undertaken jointly in drawing up a care programme for an individual resident (see Table 3 below for the headings used).

Table 3

1. Strengths and weaknesses
2. Needs
3. Aims and objectives
4. Methods: what
who
how long
5. Evaluation and review: how
when

Session 12

13. A fantasy exercise: close your eyes and imagine you are a new resident coming up the road for the first time to the home with your relative or social worker. What are you feeling? This exercise was used to encourage empathy and to open up a discussion of admission procedures

Session 14

14. Brainstorming possible activities for residents. The purpose of this exercise was to encourage creativity and to give people ideas.

Session 15

APPENDIX 5: PHYSICAL DESIGN SCHEDULE

1. Are single bedrooms available for all who want them?
2. Is the post office/local shop within easy walking distance?
3. Are bedrooms large enough for residents to bring one or two large pieces of furniture with them? For example an armchair and a sideboard.
4. Are bedrooms large enough for residents to bring one or two smaller items of furniture and effects with them? For example, a small chair, a rug, some shelving.
5. Are there electric sockets in all bedrooms?
6. Are there several small lounges or one or two big ones?
7. Are there facilities provided for residents to make tea?
8. Are the doors wide enough for wheelchairs?
9. Are there sufficient handrails?
10. If there are stairs, are there accessible lifts that residents can easily operate?

APPENDIX 6: PROCEDURES AND PRACTICES SCHEDULE

1. Do you operate a key worker system? What does it entail?
2. When do residents get up?
3. When do residents go to bed?
4. Are bedrooms cleaned routinely by staff?
5. Is there a residents' committee?
6. Is there a choice of menu (more than an alternative)
7. Are there set mealtimes?
8. Are visiting hours unrestricted?
9. Are pre-admission visits (both ways) and short stays before admission usual in non-emergency situations?
10. Do you have formal staff meetings? If so how frequently?
11. Are individual care plans and reviews made?

APPENDIX 7: POLICY SCHEDULE

Do you have a written policy document about the home? (Not a general county one but one specific to your home)

YES/NO

If yes, Please may I see a copy?

Does it include a recognition of the importance of the following:-

1. The provision of private space.
2. An admissions procedure that stresses pre-admission visits.
3. Individuality of need.
4. Choice.
5. Bringing in own furniture and effects.
6. Resident participation.
7. Residents to decide how much to do for themselves.
8. Lack of rigid role definitions between staff.
9. A key worker system to break down block treatment.
10. Regular staff meetings.
11. Community encouraged to come in.

APPENDIX 8: 44 STATEMENTS SCHEDULE

There are 44 statements listed below relating to residential care of elderly people. Please read them carefully and identify (with a cross in the left hand margin) the 11 statements with which you most strongly agree.

1. Routines are necessary and residents need to fit into them.
2. The role of resident is to make his/her own decisions about how to live.
3. A 'bad' resident is one who does as s/he is told without question.
4. A 'bad' resident is one who is always demanding his/her own way.
5. The role of staff is to take care of people's physical needs: to ensure they are clean, warm and well fed, for example.
6. Residents should all get up reasonably early: it is good for them.
7. Residents should choose when to get up.
8. Residents should decide how physically active to be.
9. Activity is good for people.
10. Residents should have a choice of menu.
11. Residents should have keys to their rooms.
12. Residents should decide how far to participate in activities.
13. Residents should not be able to lock their own rooms: it is too risky.

14. If people are feeling under the weather they should be able to choose to stay in bed.
15. Residents should have a say about when their rooms are cleaned and how much is done for them.
16. People should only be allowed to stay in bed if they are ill. Once staff realise they are better they should have to get up again.
17. Given more autonomy residents make responsible decisions for themselves.
18. The person who knows what is best for a resident is that resident him/herself.
19. Residents, especially the very frail, are a bit like children.
20. if you give residents freedom to stay in bed they will take advantage of you.
21. Staff know what is best for residents.
22. Residents are adults with rights and responsibilities.
23. Every resident should have a bath once a week.
24. Residents, of necessity, have to have decisions made for them by staff when they come into care.
25. Residents have the same human rights as other people in society.
26. Residents should decide when to have a bath.
27. Residential care is about keeping people safe.
28. If a resident wishes he/she should be able to bath alone.

29. The role of a manager (officer in charge) is, above all, to ensure that the home runs smoothly.
30. It is too risky to let residents bath without someone in attendance.
31. Residents should be kept as physically active as possible.
32. The role of staff is to enable residents to live as they want to.
33. Sitting and talking to residents is an important part of the role of staff.
34. The role of staff is to do things for people.
35. Staff should only sit and talk to residents when they have finished their other tasks.
36. The role of staff is to meet people's physical, social and emotional needs as they, the staff, see them.
37. The role of the manager (officer in charge) is, above all, to create a climate in which individual needs can best be met.
38. Residential living involves letting residents take risks.
39. It is administratively too difficult to provide a choice of menu.
40. All rooms need cleaning regularly and thoroughly by staff.
41. Meals should be at fixed times so that everyone knows where they stand.
42. It doesn't matter when beds are made.
43. Mealtimes should be flexible.
44. Routines, such as bed making, are important.

Thank you very much for your help.

APPENDIX 9: CRITICAL SITUATION ANALYSIS

The following are enclosed:

1. Brief details about a resident
2. Brief details about a member of staff
3. A letter to the officer in charge from the daughter of the resident.

Please read them carefully and then decide how you would handle the situation if you were the officer in charge in question.

1. The resident: Mrs Elsie Jones.

   Mrs Jones is 88 and suffers from arthritis. Walking is difficult and painful for her. She came into care 18 months ago after a serious fall at home. She seems to you to be well settled in the Home, although she still says she misses her garden. Mrs Jones causes few problems in the home and is generally pleasant to other residents and staff. She has one daughter, Mary, who is a schoolteacher and lives 30 miles away. Mary visits her mother quite regularly, about once or twice a month. You haven't had much contact with her, but she seems to care about her mother and be appreciative of what you are doing for her.

2. The member of staff: Jane Brown R.C.O. 1

   Jane Brown is 36 and has been working in the home for 4 years, before which she was at home with her young children. She has no training in social services work, but is an

efficient worker who gets her jobs done and who seems to get on well with colleagues and residents most of the time.

3. The letter

Dear Officer in charge,

I am writing to you about my mother, Mrs Elsie Jones. It seemed to me that she had settled quite well in the home, but just recently she has started to complain about one member of staff, a Mrs Brown, who she says is making her life a misery. She complains that Mrs Brown handles her roughly when she is giving her a bath and that she hurts her a great deal. She also says that when she asked Mrs Brown to help her to go into the garden on a fine day last week, Mrs Brown refused rudely, saying she was far too busy.

I do hope you will be able to sort this out: I hate to see my mother so unhappy. Surely staff should not be so cruel to the old people.

Yours sincerely,

Mary Jones

APPENDIX 10: JOB APPLICATION SCHEDULE

You have received applications from the following three people for a basic grade care worker. Which one would you be likely to choose and why?

Applicant 1

Susan Smith is 38 years old. She is married with 2 children in their late teens. She has worked for 3 years in a neighbouring home and she wants to move because her husband has got a new job near your establishment.

Her reference from her present officer in charge describes her as a good worker, who isn't afraid of getting her hands dirty. She undertakes her tasks with efficiency and is firm but kind with residents.

Applicant 2

Zoe Carter is 24 years old. Since she received her degree in social sciences 3 years ago she has worked in child care with disturbed adolescents. Her reference from her present officer in charge describes her as a dynamic member of staff with lots of imaginative ideas about her work. She works particularly well with aggressive and difficult youngsters who respond well to her enthusiasm and willingness to accept them as they are.

her letter of application says that she wishes to move to working with elderly people because she sees such work as the "challenge of the 1980's."

Applicant 3

Brenda Phillips is 41 years old. She has never worked in residential care, but has led an active life travelling the world and working in a variety of jobs with people. For example, during the Vietnam war, she worked as a nursing auxiliary in a hospital for disabled war veterans in America. She says that whilst working with disabled people she observed that others tended to treat them as not just physically impaired but mentally deficient also. She states that in her view this is the biggest danger of residential care and that one of her strengths is the ability to treat people in their own right, irrespective of their frailties. Her most recent job was in Ethiopia where she worked in one of the relief camps for 18 months. A reference from one of her few British employers, the organiser of a voluntary food service for down and outs in London, describes her as a charismatic person who cares deeply about people suffering from poverty and disadvantage. Her letter of application says she wants a steady job in the area, where her elderly parents live,because she feels it is time to settle down in England.

APPENDIX 11: CHARACTER PROFILE SCHEDULE

1. What characteristics would you expect to find in:

   a good resident

   a good member of staff

   a good officer in charge?

2. What characteristics would you expect to find in:

   a bad resident

   a bad member of staff

   a bad officer in charge?

APPENDIX 12: THE TOUR ANALYSIS

To be based upon observations during the tour of the home and from general discussion. Factors to be noted:-

1. Whether officer in charge introduced visitor to residents and staff met on tour.
2. Whether officer in charge knocked on residents' rooms before entering.
3. Whether officer in charge asked if s/he should show visitor round.
4. Whether officer in charge listened and responded to residents if s/he was spoken to during tour.
5. Whether officer in charge treated residents as adults/equals.
6. Whether staff or residents controlled residents' daily lives.

APPENDIX 13: LETTER TO THE OFFICERS IN CHARGE

5 Larkhall Place

Larkhall

Bath BA1 6SF

July 8th 1985

Dear

As you may know, I am involved in teaching CSS at Trowbridge College. I am also undertaking some research, for a higher degree, into the quality of the environment in elderly persons' homes.

For the first part of the research I did some work with the care staff of one home, in which we attempted, with some success, to move towards more resident oriented practices within the home.

As a result of this work I have reached some conclusions or ideas about why it is so difficult to achieve resident oriented practices in homes, and, on the other hand, the factors most likely to facilitate this. For example, it is difficult to be resident oriented if people have to sleep in double or treble rooms, thus making privacy and the recognition of individuality more difficult to achieve. It is these ideas I now want to test, by a survey of all

the homes in Wiltshire in which the officer in charge has been in post for at least two years.

The survey would entail my visiting the home and asking you a series of questions about the home and the way it is run and your views about residential care. I estimate that it would take an hour or so, to include if possible, a quick tour of the public areas of the home, particularly if I have not visited before.

Mr. Morrish, the Director of Social Services, has given me permission to contact you, but of course your participation is entirely voluntary. Your replies to the questions would be treated as confidential and when the survey results are written up, individuals and homes would not be identifiable. What I hope to be able to identify are those features of establishments which are likely to result in environments best suited to meet residents' needs.

I do hope you will feel able to participate in the survey. I will phone you in a few days to find out if you are prepared to take part and if so to arrange a mutually convenient time for me to visit.

With many thanks

Yours sincerely

Stella R. Dixon

APPENDIX 14: LETTER OF THANKS TO THE OFFICERS IN CHARGE

5 Larkhall Place

Larkhall

Bath BA1 6SF

3rd September 1985

Dear

Thank you very much for answering all the many questions I asked you on my recent visit to your home. I really appreciated the co-operation and hospitality which you showed me. I also enjoyed renewing old friendships and acquaintances and getting to know those of you whom I had not met before.

It was a fascinating experience to visit eighteen homes in one county and to see the similarities and differences at first hand. I am at present attempting to analyse all the material I collected and to make sense of the relationships which are becoming apparent.

Some of you asked me to send you the results of my research, and there seemed to be particular interest in the final schedule I used which claims to 'measure' how resident- or institution-centred an establishment is. The scale is from 0 to 77. A score of 0 would denote an extremely resident-

centred home, and 77 a very institutional one. In fact, of the homes I visited, the range was much narrower than this, with the lowest score, that is the most resident-centred, being 9 and the highest, that is the most institution-centred, being 32. Most homes obviously scored between the two extremes, with the average score being 20.

As one might expect, the newer homes with better physical provision tended to score lower than the older homes. However several older purpose built homes also achieved relatively low scores of 15 and 16, showing that one can overcome physical disadvantages, like double rooms for example, to quite a large extent.

If you would like to know how your individual home scored please do not hesitate to contact me: either on Bath 24726 in the evenings or at work on Trowbridge 3641 extension 2381.

I am sending a copy of this letter to Mr. Morrish, but will not of course identify individual homes.

Thank you again for the considerable amount of time you gave and for sharing your views and expertise with me.

With very best wishes.

APPENDIX 15

WILTSHIRE COUNTY COUNCIL

SOCIAL SERVICES DEPARTMENT

Fessey House Home for the Elderly, Brookdene, Haydon Wick

Philosophy of Care

It has been the policy of the Social Services Committee to site homes for the elderly in such a way across the county as to create a spread of this facility. The purpose has been to ensure that elderly people can be admitted to a residential establishment which is within a comparatively short distance of the place where they have lived. In this way the trauma of admission can be reduced and visiting by friends and relatives facilitated.

With this in mind a site was chosen at Haydon Wick. Already in this area there are a number of elderly people living in newly built Housing Association and Borough Council sheltered dwellings. Additionally, a local authority category II dwelling is being built on the site adjoining the Part III Home at Haydon Wick. Thus the new home will be sited in an area of new buildings where an elderly community has been created by moving people from other parts of the borough or from locations outside of Wiltshire. It is, therefore, anticipated that the new Part III Home will become a community focus for the elderly in the neighbourhood.

There are two social work teams operating within the Borough of Thamesdown, one of these teams deals with Children and Families, the other with Adult Services. The Adult Services Team has a policy of working closely with their colleagues in Residential Establishments and to this end each Part III Home has an assigned Social Worker who is the link between the Home and Community Team. A Senior Social Worker from the Adult Services Team, together with the assigned Worker and the Residential Officers are responsible for assessments and reviews of all residents within the Home.

The Adult Services Team is committed to forward thinking concepts in the care of the elderly and the integration of Social Workers, Residential Workers and the community. To this end one of the Team's Social Workers is already working in the Haydon Wick area to produce a link scheme where both old and young can benefit from one anothers skills. It is envisaged that the new residential home will be able to participate within such a scheme.

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Throughout the county we have a situation where the numbers of elderly people within the population is expanding. Research has shown that the most vulnerable section of society are those aged over 75 years of age. In 1978 there were 25,034 people over the age of 75 living in Wiltshire. This age group will increase by 18% over the next ten years and by 1991 there will be 33,000 people in this group in Wiltshire.

This expansion in the over 75 age group needs to be viewed in the light of the current economic situation and the likely inability of Local Authorities to continue building homes for the elderly to meet the projected demand. Clearly there is a need for a fresh imaginative approach to the use of existing resources and the need for the development of alternative care strategies if future needs are to be met. Currently the County Council, together with the Wiltshire Area Health Authority and the Department of Health and Social Security, are involved in a joint "balance of care" study and the initial project report points the way in which need might be met in the future with an expansion of domiciliary care and nursing services combined with a more flexible use of residential resources. This approach is echoed by a recent local working party report which reviewed the needs of the elderly within Thamesdown. This review was compiled by members of local statutory and voluntary organisations has already led to certain innovations in terms of domiciliary care and lays a framework for community care of the elderly.

Proposals

The Home at Haydon Wick will be seen as a community resource and it will be important to promote the Home as having a range of residential provision besides permanent care. Often the reluctance of elderly people to accept short stay or programmed care is a result of fears that they may be put away for good. For Fessey House to present a new image, staff need to identify the admission of an elderly person to care as a process beginning at the time of the initial application and continuing whilst the individual is actually in residential care.

It is recognised that rehabilitation programmes must be orientated towards an objective whether this be independent living in the community or a higher level of independence within the Home. Within the residential unit the focus must be the assessment of potential for independence with the aim of maximising opportunities in this direction rather than the adoption of the service level to the most dependent clients as the norm.

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Forms of Care

Thus several different forms of care should be available to cater for the residential intake to Fessey House. These reflect the wider use of the residential provision as previously outlined. During the initial phase of entering residential care all residents should be the subject of ongoing assessment. It will be practice for residents to be reviewed during the fourth week following admission. Reviews will be organised by the responsible Senior Social Worker from the Adult Services Team in Swindon but the views of the residential Social Work Team will be essential in this connection and it is expected that written review information will be produced by the staff of the Home.

(a) Permanent Care

Those elderly persons not capable of caring for themselves in their own homes or alternative community facilities. The aim would be to enable residents to maximise their level of independence within the home setting. This category excludes the chronic sick but acknowledges the population of any home will include many residents who have become increasingly dependent in the years following their admission.

(b) Short Stay Accommodation

It is recognised there are a number of frail elderly people living in their own homes who can be helped to continue living within the community by the provision of supportive services such as home help, meals on wheels, visits by the community nurse, etc. Further support can be given by arranging for such clients to have periods of care in a residential establishment on a programmed basis. It is anticipated that the Eastern Area Social Work Teams will wish to use a number of places in the new homes for this purpose.

(c) Holiday Beds

Places in the home may be used for clients who are normally dependent on relatives, to provide them with a break or to enable elderly residents in the Thamesdown area to use the home as a break from their normal routine.

(d) Rehabilitation

Residents may be assessed either at the admission stage or subsequently as suitable and wanting to move back into the community. Furthermore, some elderly clients admitted as "emergency" sometimes make a

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marked improvement following a period of care and in such circumstances and in conjunction with the Field Social Work Team there is a need to jointly recognise that the objectives for this client is a return to his/her own home or to sheltered housing accommodation. Whilst it may prove difficult for the staff of the home alone to carry out a programme of rehabilitation for clients within their care the Field Social Work Team are looking at the possibility of making available some services from an Occupational Therapist and also the possibility of a joint approach with the hospital services and with the Borough Council.

Allocation of Residents to Fessey House

The Eastern Wiltshire Area Management Group are accountable for the allocation of beds to those clients assessed as requiring residential care. Most of this function has been delegated to the Social Work Teams who are responsible for placements within their areas. Within Thamesdown the Team Manager Adult Services is responsible for Part III placements. This is achieved via an allocations meeting which is made up of representatives from the Area Social Work Teams both community and hospital. It is proposed that when a vacancy occurs at Haydon Wick the Head of Home or their Deputy should attend this meeting. Following the allocation meeting the Head of Home will arrange with the prospective resident to visit Fessey House. New residents will be admitted on a one month "trial" basis at the end of which a review will be held.

Background to design of the home

Various attempts have been made to break the rigidity of life in homes for the elderly. It is, of course, dangerous to generalise but it might be held that on the whole the size, shape and organisational features which are part and parcel of the residential home grind down the possibility of sustaining an enhanced social climate. Efforts to make opportunities for client independence, for greater choice, for more social interaction flounder because the elemental factor in maintaining an assemblance of order and an achievement of work must, without option, be based upon adherence to routine and time keeping. The alternative could well be chaos and an environment which gives an indifferent and patchy service.

Fessey House reflects ideas intended to escape from convention. It seeks to focus staff work upon individual personal needs rather than upon impersonal tasks. Thus clients will receive the service they need rather than receive the service because it is available and because it disrupts the harmony of the routine not to give it.

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At Fessey House we hope to turn our backs upon set routines and introduce a series of options to clients in a manner that ensures delivery of necessary services but does not create an impossible task for staff. This is, of course, not a new idea but the weakness of previous attempts to do this may have been increased both by the unreal expectation of residents and staff and also by the unsuitability of the physical environment. It is not fashionable to suppose that architectural features affect good caring, but it is foolish and wrong to suppose that they play no part at all and at Fessey House we have increased the size of residents' rooms to the maximum possible within government guidelimits. To achieve this increase in size, it has been necessary to give up a good deal of the conventional sitting/lounge space in the home. The effect is that Fessey House is a 50 place home with larger than average bed sitting rooms (12 metres square), with very little lounge accommodation. The lounge accommodation which is available is adjacent to the dining area and bar and is shared with the day care clients. The day centre, providing 20 places per day, is largely integral with the home's central service area because it is thought that when residents have their own bed sitting rooms closely identified with them, day clients will pose less of a threat and may indeed be welcomed.

Bed sitting rooms

Clients bed sitting rooms have little in the way of fitted furniture. A bed is supplied with the rooms on the ground, but height, access, size and so on can be critical and also because light switches, etc. are located with particular reference to standard beds. There is a wash basin in each room and space for a large wardrobe which can be brought by clients from their homes. The window end of the room normally has a unit only, with storage cupboards under the worktop, which is intended as a place at which residents may dine in their own rooms if they so wish. This furniture includes units with lockable storage for tea, milk, jam pots, etc. and immediately above the worktop there is a socket outlet for a kettle so that residents may make hot beverages. The wash basin will have taps positioned at a height which will facilitate the filling of kettles. There is ample room if residents wish to bring to the home with them two large armchairs in addition to a sideboard or small chest of drawers. Each room has T.V. and V.H.F. radio aerials. Special consideration has been given to the positioning and type of lighting to ensure brightness where it is needed and central pendant lighting on a domestic scale in the sitting area. Lights can be operated from the bed head if required. Any deficiency of residents' furniture either at or subsequent to admission can be made up by the County

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Council as necessary. The staff will be expected to give advice and acceptance in the manner of choosing furniture.

Delivery of meals

A particular feature is the method of delivery of meals. It may be that in many conventional homes the serving of meals in quantity at set times by few staff is one of the prime causes of regimentation in homes for the elderly. With conventional facilities it is difficult to know how to avoid this. Fessey House offers an opportunity to break away and clients shall have the option of either eating in their own rooms or in the central restaurant. It is intended that meals will be available for delivery to residents' rooms prior to the serving of meals in the main restaurant and that the same staff having completed this task should then return to the kitchen area for service there. Residents able to help themselves can obtain their food from the servery which leads directly off the kitchen or staff will assist them in the customary way. The area adjacent to the restaurant is the only large communal area in the home. There is insufficient room for all the residents to sit in easy chairs in this area at the same time and neither is it intended. If an occasion arises when residents are all together they will need to spill over into the restaurant area. There is a coffee/tea/drinks bar for residents and in which they can participate.

Residents will doubtless spend a good deal of time in their own rooms. They will, for instance, feel no compulsion to get up or leave their rooms at a fixed time in order not to miss a meal. There are complications in serving hot breakfasts to rooms, but it is intended that light, cold breakfasts of a continental style should be available and can be left in the rooms. Thus a person can get up as and when he or she wishes, make a cup of tea and not necessarily make a demand upon the staff. Other meals can be served hot or cold to rooms direct. If residents show signs of withdrawal and insularity the professional staff of the home will be expected to have cognizance of this and decide whether or not this reflects the personality and wish of the individual or whether there is a need for greater support and time in meeting that person's changing needs.

The extent to which these ideas can be carried successfully into practice will depend entirely on the skills and commitment of the staff to see they work. The job of manager does not call for a person who is complacent nor a person who needs to be reminded of his stature as Officer-in-Charge. It calls instead for an unusual depth of understanding of the effects of the institution upon residents and staff. It also calls for the ability to stand back from situations and refrain

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from making decisions for other people. It means running an organisation in which the staff assess and attend to people's individual needs and do not relate their work to sets of rigid tasks. It offers a unique opportunity to develop an original and exciting home which is already the subject of a great deal of interest and has enormous potential for deployment of personnel in an unconventional manner.

Caring services

Wiltshire's traditional complement of staffing for a home such as Fessey House would include a high proportion of care assistants. In this instance, other than night staff who will be on duty from 10 p.m. to 8 a.m., the hours previously used for care assistant staff have been redesignated to residential care staff. In effect this means that all staff of the residential home with a direct caring responsibility will be under National Joint Council Conditions of Service. The manual grades working in the home will be limited to domestic cooks and a part-time gardener/handyman. The purpose of doing this is to recognise that every caring task requires an attitude of mind and a skill which should not be taken lightly. There will be no "us" and "them" and no sharp division of tasks, but there should emerge the creation of a strong team. It follows that no-one should hide behind seniority as an excuse for not getting involved in the physical side of the caring task and although there will obviously be a certain amount of delegation, it is expected that all staff will show a common concern to the residents when they need help.

It is customary to allocate work according to the jobs that are routinely held to be necessary. For instance, a night care assistant might make the beds and tidy rooms along a certain corridor. Normally this would be done to a set standard whether or not its doing warrants it. At another home residents' rooms are regarded as primarily the domain of the residents and, therefore, private. Any intrusion into this area should be done discretely and with sensitivity and if possible avoided. There is no automatic right of entry except in an emergency. Residents will have different levels of what they regard as acceptable domestic standards and this will vary from one person to another. As far as possible staff are asked to resist the temptation to go into such situations and rationalise the standard to that which normally prevails in County Council Homes. This is, of course, not to say that rooms should be left dirty and unhygienic but it may be that they have some dust and many muddles. The headquarters staff will be more than willing to give support and advice in this difficult area.

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Domestic service

Similarly domestic services to rooms will be kept to an absolute minimum and only undertaken where there is a risk to health or unpleasant conditions. Domestic staff will be engaged in the cleaning of the corridors, lounge, communal areas, bathrooms, toilets, kitchen and dining areas etc. Domestic staff have a place in the overall staff team and will not be excluded from the appropriate meetings of staff, etc.

Accounts

Depending upon local circumstances and the proximity of the nearest post office residents should be encouraged wherever possible to draw their own pensions and to be responsible for making payment to the manager of their weekly charge.

Resident participation

The majority of the residents will live at Fessey House on a permanent basis and they must, therefore, have the major say in the direction of their own lives. The purpose of the home is to provide supportive care and this should not be interpreted as "care and control". There is a wide range of issues upon which residents can and should be consulted and their expressed wishes should not be denied merely because it may be considered by staff to be against their best interest so to do. As with any group they must take responsibility for themselves and their actions.

Residents' furniture

There is a real opportunity to bring some furniture into the residents' rooms and this should be exploited to the full. It will serve to individualise rooms and to increase the awareness of supportive staff that the territory is private.

Routines

Fundamental to the working of Fessey House will be the extent to which a break can be made in set routines. Meal times traditionally dictate and regiment homes for the elderly. At Fessey House residents can make a distinct choice about whether they breakfast in the restaurant or in their own rooms and if the latter, they can choose to stay in their own rooms as long as they wish. As to cleaning and caring, services will be directed to identify or express needs only. There are many residents who would choose to take advantage of this and should not be inhibited about this by subtle staff pressures. Similarly, lunch and the evening meal can

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be taken by residents in their own rooms. The option here is on the resident to choose and not on the staff to decide whether they are prepared to extend a favour. The success of Fessey House as a living unit will be judged largely upon the success of this aspect.

Method of meals delivery

As stated residents shall have the choice to eat in their own rooms or in the restaurant; meals served in the restaurant will normally offer a choice and would be extended over a period of time. One member of staff should suffice to serve meals in the rooms and in the restaurant as the operations follow one upon the other in that order. Breakfast will be served cold to rooms, but cooked in the restaurant. In this way residents wishing to remain in bed will feel under no compulsion to get moving quickly. Evening/night staff can undertake to ascertain those residents wishing to take breakfast in their own rooms. The service of meals in this way will not produce the cohesion which one sees in traditional homes and residents could go for several days without seeing many of their colleagues and if that is their wish, so be it.

Residents should be able to invite occasional visitors to the home, dine with them, for which an appropriate charge will be made.

Key worker concept

This concept has been used recently in a number of our homes for the elderly with good effects by enabling residents to have individual relationships with key members of staff. The use of such a concept would appear to be even more important at Fessey House where there will be residents admitted for short stay and rehabilitation in addition to those residents who are at Fessey House on a permanent basis.

Staff meetings

The department has a high regard for the importance and value of staff meetings as a means of improving care practices, promulgating the policies and objective of the establishment as a forum for discussing management issues.

Titles

This is a difficult area because few titles seem to satisfy both the need for informality with residents and the needs of the organisation. The name manager is currently in use within the county and this may suffice, but the mode of

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address to be adopted in practice in the home, if indeed, any title at all is found to be necessary, is one which the staff should share with each other and the residents. In any case the use of superintendent, deputy superintendent, matron, deputy matron, nurse, etc. will not be permitted.

Conclusion

The philosophy for the care of the residents and the involvement of the Field Work Staff in an assessment and review procedure is clearly a new departure and one which will require maximum commitment from all staff and to allow residents to maximise their potential within the home or the community. Whilst it is accepted that the Officer-in-Charge of the home is responsible to the Director of Social Services for the management of the home, nevertheless the home and its residents are viewed as part of the local community and the necessity for the staff of the Home to work in partnership with the Field Social Work Team in the day to day care and review of the residents is of vital importance.

GCWP/TGSC

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